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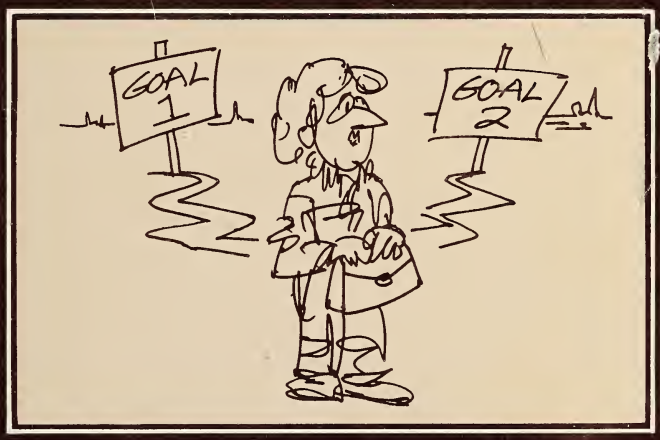
Therapist's Manual for Secondary Prevention of Alcohol Problems



PROCEDURES FOR TEACHING MODERATE DRINKING AND ABSTINENCE

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ADDICTION RESEARCH FOUNDATION

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A THERAPIST'S MANUAL FOR SECONDARY PREVENTION OF ALCOHOL PROBLEMS

Procedures for Teaching Moderate Drinking and Abstinence

MARTHA SANCHEZ-CRAIG

ADDICTION RESEARCH FOUNDATION

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OVERVIEW

This manual presents a description of procedures that we have found useful in teaching problem drinkers how to reach and maintain moderate alcohol use or abstinence. The theory underlying the procedures views excessive drinking as a learned behavior, rather than a disease or the symptom of some psychopathology, and a behavior that can be modified by methods based on principles of learning. Hence, this manual should be useful to therapists who feel comfortable with these basic ideas. Those therapists convinced by the theory that alcohol abuse is the symptom of an irreversible disease process are unlikely to find it helpful.

This treatment approach is intended primarily for early-stage problem drinkers, rather than chronic alcoholics. Many such persons want help but are reluctant to attend traditional alcoholism programs. Characteristically, these programs demand that clients acknowledge that they are "alcoholic" or diseased, that they commit themselves to a goal of lifelong abstinence, and that they absent themselves from work and family responsibilities to participate in treatment. These demands tend to be unattractive or unacceptable to most early-stage problem drinkers, who do not see them as being compatible with their needs.

When we evaluated our preventive program with 70 early-stage problem drinkers, we learned that many had felt the need for treatment long before they applied to the program at the Addiction Research Foundation. Reasons they gave for postponing treatment included: concerns that the time commitments required by available alcoholism programs would interfere with their jobs and family responsibilities; unwillingness to comply with the requirement of lifelong abstinence, which they believed would be imposed upon them in most programs; fear of being labeled "alcoholic" and the consequent embarrassment to family and friends; and the risk of losing anonymity by attending inpatient or group therapy programs. It was fear that their drinking presented a serious threat to their jobs, studies, or important relationships that motivated them to seek treatment. Generally, these early-stage problem drinkers saw themselves as being competent and able to take control of their lives. A priority for them was to do something about their drinking as soon as possible.

Based upon these findings, we are presenting in this manual a treatment program that we hope will meet these identified needs of early-stage problem drinkers. At the same time, we have incorporated those elements of treatment that we have found to be most useful in achieving the goals of treatment. These procedures have been developed over the course of more than 10 years of research into the treatment of alcohol problems (Sanchez-Craig & Walker, 1974, 1975; Sanchez-Craig, 1975; Walker et al., 1974; Sanchez-Craig & Walker, 1982; Walker et al., 1982; Sanchez-Craig et al.,

1984). As with other multi-modal behavioral therapies (Miller & Mastria, 1977; Chaney et al., 1978; Miller, 1978; Miller et al., 1980; Alden, 1978, 1983) the principal focus of this treatment program is the clients' drinking behavior and the problems directly associated with excessive drinking. The emphasis is on teaching skills for self-observation and self-control, that is, skills that enable clients to assess their progress objectively and to resolve problems that may interfere with the attainment of their drinking goal. This approach is different in that it emphasizes the need for cognitive coping, particularly to counteract tendencies to drink inappropriately.

Since the procedures described in this manual are straightforward and objective, they can be readily learned by practicing therapists. As for the client population, we have found that early-stage problem drinkers respond very positively to this approach. Of the 70 clients who were admitted to our preventive program, 67 completed treatment, and most of these rated the helpfulness of the program highly when they were interviewed at various stages of the two-year follow-up.

This manual has been divided into three main sections. In the first, criteria and procedures for screening appropriate clients are outlined; included in this section is a brief questionnaire that may be used to obtain relevant information about alcohol use. The second section provides a detailed description of the treatment procedures. The third section contains a summary of the theoretical background of the program, the empirical findings to date, and the issues surrounding the controlled-drinking controversy. Therapists who are not acquainted with this controversy are advised to read this section first. Reading the theoretical background and the research associated with the program may also give a better understanding of the treatment procedures.

INITIAL ASSESSMENT

This section includes:

- Criteria for the Selection of Appropriate Clients
- Brief Questionnaire for Assessing Alcohol Use

CRITERIA FOR THE SELECTION OF APPROPRIATE CLIENTS

Who is most likely to succeed in achieving moderation of alcohol use? The presence of the following indicates that someone would have a good chance of moderating alcohol consumption:

- The belief that moderation is a valuable and attainable goal.
- The belief that pursuing the goal of moderation will not threaten important relationships or the security of a job.
- A social network supportive of the goal of moderation.
- Willingness to commit time and effort to the achievement of the goal.

Typically, problem drinkers who succeed in achieving moderation are healthy and socially stable; they tend to have brief histories of problem drinking and relatively low levels of alcohol dependence.

Some drinkers who have an advanced problem may adamantly refuse to abstain, even though they know that *any* drinking will probably worsen their health or their problems at work or home. Although in such cases abstinence would be the therapist's preferred goal, moderation may be the only practical one.

We have used the following criteria to select clients:

Good Physical and Mental Health. There should be no evidence of a medical condition for which any drinking is contraindicated (e.g., liver or brain damage, alcoholic myopathy, diabetes, pancreatitis, clinical depression, psychosis). Before training in moderation of alcohol use is initiated, the candidate should be examined medically. Also, if the candidate is in emotional turmoil (e.g., arising from the loss of a loved one, the loss of an important job), we recommend that training be postponed.

Normal Cognitive Abilities. It has been shown consistently that excessive drinkers tend to have impaired problem-solving ability and impaired ability to learn new things (Parsons & Farr, 1981; Wilkinson & Carlen, 1981). Since the program emphasizes the teaching of problem-solving skills, it is important to ensure that clients are cognitively intact so that they can benefit from treatment.

At the Addiction Research Foundation, tests used for preliminary screening of cognitive functioning are: the *Trail Making Test* (Reitan, 1958) and the *Digit Symbol Substitution* and *Vocabulary* tests of the WAIS (Wechsler, 1958). If performance on the Digit Symbol test is more than two age-scaled points lower than the performance on the Vocabulary test, or if Trail Making test performance is in the impaired range, more extensive neuropsychological assessment is necessary.

Social Stability and Appropriate Social Supports. Treatment will more likely be successful if a problem drinker is socially stable and has a social network supportive of a goal of moderation. Involvement in such activities as work or school and having a family or stable relationships are also desirable. It is important that the client's close friends and family support moderation as the goal. If, for example, the spouse believes that total abstinence is the only solution to the problem, it will be difficult for the client to achieve moderation.

Brief History of Problem Drinking. On average, the 70 clients admitted to our program had a history of problem drinking of approximately five years: that is, five years had elapsed since their drinking began to interfere with their performance at work or school, their family or social life, or their health. The criterion we have adopted in selecting clients for goals of moderation is a maximum of 10 years of problem drinking.

Low–Moderate Level of Alcohol Dependence. Alcohol dependence is characterized by impaired control over drinking, salience of drinking-seeking behavior, increased tolerance to alcohol, repeated alcohol withdrawal symptoms, and awareness of a compulsion to drink excessively. The alcohol dependence syndrome was first described by Edwards and Gross (1976) and is central to the classification of alcoholism adopted by the World Health Organization.

Assessment of the level of alcohol dependence can be made swiftly by using the *Alcohol Dependence Scale (ADS)*, which includes only 25 items (Horn et al., 1984). The ADS and guidelines for its use have been prepared by Skinner and Horn (1984), and these are available from the Addiction Research Foundation.* The average score of the 70 clients admitted to our program was approximately 14.0 (SD = 7.0), which is lower than the average score of the general patient population of the Addiction Research Foundation by about 10 points. This difference in level of dependence is statistically significant.

Excessive Drinking as the Main Presenting Problem. The clients we have treated with the approach described in the manual have not been simultaneously abusing alcohol and other psychoactive drugs, with the exception of nicotine. Since the procedures have not been tested with multi-drug abusers, they cannot as yet be recommended for such clientele. We are currently testing the procedures with regular users of prescribed benzodiazepines.

*Write to Addiction Research Foundation, Marketing Services Department, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1, or telephone (416) 595-6056.

ASSESSMENT OF ALCOHOL USE

Selecting an appropriate drinking goal—and formulating a plan for moderate drinking if such is the goal—requires knowledge of the client's drinking history and social environment. If this information is not otherwise provided, the *Alcohol Consumption Questionnaire* on page 6 will elicit the relevant data. This questionnaire covers such areas as: length of time of the drinking problem, previous attempts to abstain or to moderate alcohol use, current pattern of alcohol use, levels of consumption associated with problem and problem-free drinking, consumption of other psychoactive drugs, level of consumption by others in the home, and support expected from important others (e.g., spouse, partner) regarding the drinking goal.

The previous three months is recommended as a sufficient period over which to assess consumption levels. This period is long enough to detect low-frequency intermittent drinking and short enough to avoid problems of recall. Also, in our study with the 70 early-stage problem drinkers, we found that drinking reported by these clients for the three months before treatment correlated very highly ($r = .90$) with drinking reported for the previous year. However, the therapist is advised to check whether the quantity and frequency of drinking and the drinking pattern reported for the previous three months are *representative* of the client's drinking for the previous year. If not, the client should be asked to specify the differences.

Definition of a Drink

In Ontario, most regular beers contain about 5% absolute alcohol by volume. Most table wines contain 10%–14% absolute alcohol, but fortified wines such as sherry, port, and vermouth contain 14%–20%. Distilled spirits—whiskey, rum, gin, etc.—contain approximately 40% absolute alcohol.

At the Addiction Research Foundation, one standard drink is defined as:

12 oz (341 mL) of regular beer
5 oz (142 mL) of table wine
3 oz (85 mL) of fortified wine
1½ oz (43 mL) of spirits

Each of the above units contains about .60 oz, or 13.6 g, or 17.4 mL of ethanol. Investigators in the United States allow only .50 oz of ethanol per standard drink, which represents 20% less than the amount allowed in Canada.

Since the alcohol content in beverages and the size of drinks vary from country to country, you are advised to inquire what constitutes a standard drink in your particular community. If there is a substantial difference from the A.R.F. definition, adjust the quantities in the questionnaire accordingly.

ALCOHOL CONSUMPTION QUESTIONNAIRE

Date _____ Name _____

1. Years of problem drinking (time since drinking began to interfere with the client's functioning in important life areas, including health): _____
2. Years since 4 or more drinks have been regularly consumed on 3 or more days per week: _____
3. Previous attempts to abstain or to reduce drinking—with the help of other professionals, treatment centres, A.A., etc., or on his/her own.

   Please specify: _____
4. Drinking pattern in the previous 3 months (circle appropriate category):
   - 0—abstinent
   - 1—occasional/weekend
   - 2—binge (drinks heavily for several days or weeks, with periods of abstinence or very light drinking in between)
   - 3—frequent (drinks 5 or more days per week)
   - 4—daily
5. Quantity and frequency of drinking in the previous 3 months:

Quantity	No. of days
0	_____
1–4	_____
5–9	_____
10+	_____
Total =	90 days

6. Number of drinks consumed when drinking interferes in any way with the client's functioning in relevant life areas (state range):
   From _____ to _____
7. Number of drinks consumed when drinking is problem-free (state range):
   From _____ to _____
8. Maximum number of drinks consumed in a single day in the previous 3 months: _____
9. Consumption of other psychoactive drugs:
   —prescribed (e.g., tranquillizers, sleeping pills)
   —non-prescribed (e.g., cannabis)
   Please specify kind, dose, and frequency: _____
   _____
10. Specify who lives at home, and whether each of these persons drinks *less* than the client, drinks *about the same*, or drinks *more* than the client:
    _____
    _____
    _____
11. Are persons living at home likely to support the client's drinking goal? Yes, With reservations, Not at all:
    _____
    _____
    _____

TREATMENT PROGRAM

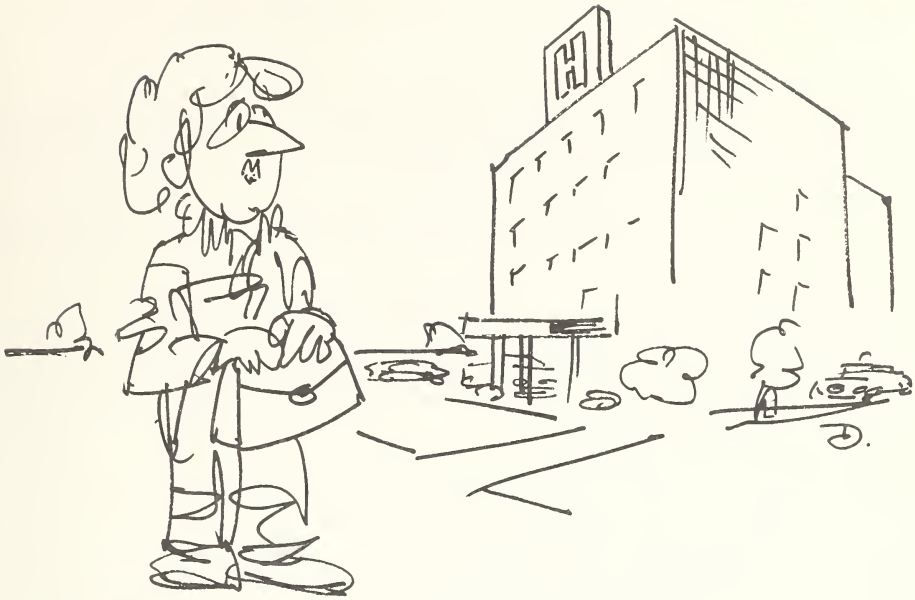
The treatment program consists of three main phases.

Preparatory Phase. When clients present to treatment, they may have a drinking goal in mind, or they may wish to discuss one with the therapist. Whatever goal is agreed upon should be considered only an *initial* goal, until information is obtained that permits informed discussion between client and therapist of the appropriate longer-term goal. This phase is designed to gather such information. Also, during this phase information is obtained about situations where the client is at risk of drinking excessively, and about competencies that the client may already have to deal with these risk situations. This phase is usually covered in three counseling sessions scheduled one week apart.

Acquisition Phase. At the beginning of this phase the longer-term drinking goal is specified. The emphasis during this phase is on teaching skills that help the client to abstain or to drink only within the established limits. The client learns to test the selected drinking goal, and to develop specific strategies for coping with problems that may interfere with the acquisition, or the maintenance, of the desired drinking pattern. This phase is usually covered in three or four counseling sessions scheduled one week apart. *Note*: The Preparatory Phase and the Acquisition Phase are separated in this manual for reasons of conceptual clarity. In practice the procedures often overlap, and they cannot be neatly separated.

Maintenance Phase. This phase is open-ended. The objective is to ensure that the client maintains the gains of treatment. Regular contacts are planned for at least six months following treatment to encourage the client to continue to apply the strategies learned in treatment. Such contacts may be face to face or over the telephone. Booster sessions are provided, if needed.

Since the large majority of early-stage problem drinkers choose a moderate drinking goal, the treatment procedures will be described with such a goal in mind. Remarks regarding the teaching of abstinence will be made as required.



PREPARATORY PHASE

This phase has the following components:

- Introduction to Treatment
- Request for an Initial Period of Abstinence
- Identification of Aids for Reaching the Initial Drinking Goal
- Introduction to Self-Monitoring of Drinking Behavior
- Identification of Risk Situations and Existing Competencies

INTRODUCTION TO TREATMENT

During this introduction the therapist outlines the objectives of the program and describes the client's responsibilities. Explain to the client that the principal aims of the program are:

1. To identify those situations in which drinking has been a problem, that is, the risk situations.
2. To teach strategies to develop more appropriate coping responses in those risk situations.
3. To help develop a safe drinking pattern.
4. To teach procedures for monitoring progress towards the drinking goal.

Inform the client of the expected number of sessions, the approximate length of each session, and the therapist's expectations (i.e., punctual and regular attendance, notification of cancellations, the completion of homework, and the placing of high priority on the treatment). Emphasize that active participation in the treatment is expected, and that failure to keep appointments or do homework may result in discharge. Also emphasize that if the treatment procedures are followed systematically, and with persistence, the client can achieve the goal of moderation or of abstinence.

Once the treatment objectives and program requirements have been discussed, invite questions about the program. Clients often inquire about the program's success. We tell them that an evaluation of the treatment with 70 problem drinkers at the Foundation showed that when these clients presented to treatment, most of them were daily drinkers, and on average consumed about nine drinks per day. Six months after discharge from treatment, their average consumption on drinking days had been reduced to about four drinks, and they drank only three days per week on average. This pattern of moderate drinking was maintained by most clients over a two-year period (time of their last follow-up contact).

A second question clients often raise concerns the nature of alcoholism. We tell them that there are several hypotheses (e.g., that alcoholism is the result of a metabolic or biochemical imbalance; of faulty upbringing and bad influences; of unresolved oral conflicts; of having no meaning in one's life), but that no one knows for certain which, if any, of these views is correct.

The current trend is to believe that alcoholism is a *disease* that can be arrested only by total abstinence, and many people consider the source of the disease to be a special chemistry that prevents the person from drinking moderately. However, the disease model of alcoholism is an untested hypothesis, and no special chemistry has yet been identified. There is also abundant evidence to suggest that many heavy drinkers learn to control

their drinking, especially when they are socially stable, under 40 years of age, and have histories of problem drinking of less than 10 years.

We believe that excessive drinking is to a large extent a *learned behavior* that can be modified by methods based on principles of learning. According to the learning view, high-frequency heavy drinking should be modifiable to low-frequency moderate consumption, or to abstinence. Hence, in theory, abstinence is a possible but not a necessary objective of treatment.

Tell clients who opt for a goal of moderation that conflicting opinions are likely to be offered by people who consider themselves knowledgeable about alcoholism. Some may assert that moderation is ill-advised or unachievable, and that those who try it will be harmed. The client should therefore be careful about discussing freely a chosen goal of moderate drinking.

REQUEST FOR AN INITIAL PERIOD OF ABSTINENCE

In a program such as this, where emphasis is placed on the teaching of problem-solving skills, an initial period of abstinence is highly desirable. Our research has shown that when clients abstain, or reduce their consumption to an average of one drink or less per day during the first two to three weeks of treatment, it gives them an opportunity to sharpen intellectual abilities that may have been dulled by their alcohol consumption (Wilkinson & Sanchez-Craig, 1981). Also, during this initial abstinence period, clients have an opportunity to identify the coping responses they *spontaneously* use to counteract urges to drink and to refuse invitations to drink.

Explain to the client that moderation may be reached in three ways:

1. By reducing drinking gradually until the desirable drinking pattern is achieved.
2. By introducing a moderate-drinking regime from the beginning of treatment.
3. By introducing a moderate-drinking regime after a short period of abstinence.

The advantages of maintaining abstinence (or reducing alcohol consumption dramatically) for at least the first two weeks of treatment can be stressed by offering the following rationales:

> Regular heavy use of alcohol for five or more years tends to dull people's cognitive abilities. Heavy drinkers often lose part of their capacity to abstract, to solve problems, and to learn new things. Our research, however, has shown that when drinkers with characteristics similar to yours abstain, or reduce their alcohol consumption to an average of one or fewer drinks a day, their intellectual abilities sharpen again. Since the program requires that you learn a number of new skills, two to three weeks of abstinence will probably contribute to better learning.
>
> When heavy drinkers attempt to abstain, they usually experience two types of difficulties: their own temptations to drink and pressures from others to drink.
>
> A short period of abstinence is highly desirable, since it will give you an opportunity to observe how you cope *spontaneously* when you succeed in counteracting your own temptations and invitations from others. If you manage to identify effective coping responses—of which you may not be aware—this can save a significant amount of time and effort in therapy.

Once the advantages of an initial abstinence period have been presented, the idea of a period of two to three weeks of abstinence can be explored. Is it realistic, or will anticipated difficulties require a more conservative route (e.g., gradual reduction of drinking)?

If the client agrees to abstain for the two or three weeks, the client's level of confidence in abstaining for that period should be evaluated. Is the client *very confident*, *fairly confident*, *moderately confident*, or *not confident at all* that he or she can remain abstinent? This information is relevant since research has shown that expressing confidence in one's ability to do something is an excellent predictor of success (Bandura et al., 1977). If the client admits to only moderate (doubtful) confidence or none at all, the anticipated difficulties can be explored and an alternative route to moderation considered.

Clients sometimes anticipate difficulties, such as an approaching birthday or wedding when they would like to have a few drinks to celebrate. Such "difficulties" do not warrant a different approach, since the client could simply restrict drinking to the special event and remember to maintain abstinence for the rest of the time.

Other difficulties sometimes relate to fear of suffering withdrawal symptoms or fear of failure. Some clients say they have experienced "bad" withdrawal symptoms (and grew frightened when they previously tried to abstain). Others argue that they have to proceed slowly and "take small steps" in order to reach goals. These fear reactions usually come from clients who have consumed large amounts of alcohol on a daily basis (10 or more drinks). In such cases, gradual reduction of drinking levels is advised.

With gradual reduction, ask the client to specify the quantity by which drinking will be reduced during the upcoming week and the times when these reductions will occur (e.g., martinis at lunch, cocktails before dinner). Once the client has set a goal, a confidence rating should again be taken, using the four-point scale described above. Once again, if low confidence is expressed, a less demanding goal should be explored. (This process can be repeated at every session until a desirable drinking pattern is achieved.)

If the client is taking prescribed psychoactive drugs (e.g., tranquillizers), and agrees to maintain abstinence for the first two to three weeks, he or she should keep a daily record (log) of the dose(s) consumed. It is important to ensure that during the abstinence phase the client does not compensate by taking other drugs. If non-prescribed psychoactive drugs are being used for recreation purposes, ask the client to abstain from them during the initial period of abstinence.

Compliance with an Initial Period of Abstinence

In our study with the 70 early-stage problem drinkers, 35 of them were assigned to a goal of moderation and 35 to a goal of abstinence. Of those assigned to moderation, 14 abstained and four reported an average consumption of one drink or less per day. We can therefore expect that when clients similar to those in our study are given the option of pursuing moderation, about *half* will comply with the request for an initial period of abstinence, or of very limited drinking.

IDENTIFICATION OF AIDS FOR REACHING THE INITIAL DRINKING GOAL

Regardless of whether abstinence or reduction of alcohol use is the initial goal of treatment, help the client to identify strategies and activities that might make achieving the goal easier. These may include:

- Seeking support from family or friends.
- Allowing no alcohol in the home.
- Avoiding contact with heavy drinkers.
- Engaging in activities incompatible with heavy drinking.
- Self-monitoring of drinking behavior.

Avoidance of heavy-drinking friends, and places where heavy drinking occurs, is accepted by the therapist only as a temporary strategy, until the implications of such actions for the client's life are discussed, or until the client develops strategies for coping with urges and social pressures to drink.

Stress the importance of engaging in activities incompatible with drinking to fill those periods when the client drank heavily. Some examples include participating in educational or physical fitness programs or in recreational activities, developing hobbies, or switching to a social life more supportive of the goal.

Point out to the client that those who fail to moderate their drinking usually have not filled the *vacuum* left by their reduced drinking with other pleasurable activities.

If the goal is to reduce consumption, instruct the client in the *pacing of drinking*. The following measures can be very helpful in slowing drinking down and avoiding intoxication:

- Measuring drinks, rather than just pouring them.
- Diluting drinks, rather than having them straight. (In diluting drinks, carbonated beverages should be avoided since they increase the rate at which alcohol is absorbed.)
- Spacing drinks by letting at least one hour pass before taking the next drink.
- Alternating alcoholic and non-alcoholic drinks.
- Avoiding drinking on an empty stomach.

Homework Assignment

Ask the client to: 1. make a list of enjoyable things to do during those hours when heavy drinking once occurred: 2. self-monitor his or her drinking, as described in the section below; and 3. self-monitor consumption of prescribed psychoactive drugs, if this applies.

The client should bring the list of activities and the self-monitoring records to the next session.

INTRODUCTION TO SELF-MONITORING OF DRINKING BEHAVIOR

Self-monitoring—a central component of this program—can be defined as the systematic observation and recording of one's behavior. We use this procedure for several reasons. First, self-monitoring has proven to be effective in reducing the frequency of various problem behaviors (Nelson, 1977). Second, it helps to identify risk situations. Third, it permits objective assessment of progress towards the drinking goal. Finally, our research has shown that drinking is more reliably assessed by self-monitoring than by recall (Sanchez-Craig & Annis, 1982).

Self-monitoring is introduced with the following rationale:

> All our clients are asked to keep track of the their drinking. Some of them do it and some do not. Some react against self-monitoring because they perceive it as a lot of work with no obvious payoff.
>
> And hard work it is. It requires commitment and iron self-discipline. But the payoff, though not immediately evident, tends to be substantial. Clients who do it report that it gives them tremendous understanding of events where they are at risk; that it helps them to develop self-control; and that it permits them to assess their progress more objectively.
>
> Research has consistently shown that when people keep track of an unwanted behavior, it reduces the frequency of engaging in the behavior. We also find that clients who persist in monitoring their drinking tend to drink less when they do drink.

Show the client how to record abstinent and drinking days on the self-monitoring form presented on page 17. For abstinent days, a "0" is entered in the appropriate space. For drinking days, space is provided to specify the number of drinks consumed, the types of drinks, and the occurrences of morning drinking. The form also includes space to record the client's target goal for a given week, the weekly total of abstinent and drinking days, and the number of drinks consumed.

The self-monitoring forms can be adapted to obtain drinking data for longer periods of time if decided (e.g., one month), or to have clients record other aspects of their behavior. However, the simpler the request, the more likely that clients will comply with self-monitoring.

Emphasize the importance of recording *accurately* each day's drinking. If the client decides on abstinence and then "slips," the number of drinks consumed should be recorded, even if it is only one or "part of one." Similarly, if the client has agreed to taper off, and then breaks the drinking rule, the number of drinks should be recorded. Make it clear that violations of rules are not cause for shame or punishment, but should indicate situations requiring coping skills. Point out that self-monitoring of drinking behavior is an ongoing process.

Homework Assignment

Instruct the client to keep a daily record of his or her drinking. Recommend that a specific time each day (e.g., just before bed) be selected to make this record. Ask the client to bring the record to each treatment session.

The Therapist's Use of This Information

First ensure that the drinking record is complete. If even a day is missed, ask the client to recall the information as accurately as possible and stress again the importance of keeping an exact record.

During each treatment session, it is wise to plot the drinking reported by the client for each day since the previous session (see pages 18 and 19 for examples of graphs). This provides an easily interpretable indication of progress; also, it motivates clients.

If the client achieved the drinking goal, ask him or her to discuss the difficulties in doing so and the aids or techniques that helped.

Clients who fail to keep to the drinking goal (even though only once or twice) tend to become discouraged and pessimistic. In such cases, it is a good idea to point out the number of days that the client was on target, and compare them with the client's pretreatment behavior—especially noting any significant progress. Client and therapist should then specify the incidents of excessive or problem drinking (using a form designed for this purpose described on page 28 of the manual). These incidents can be used at once to help the client develop coping skills. For each drinking incident, ask the client to think of responses that could have prevented the slip (i.e., what the client could have *done* or *said to him / herself* to prevent the slip).

If the client's performance fell far short of the expectations, reexamine the goal to determine whether it was realistic.

Clients can be encouraged to keep weekly or monthly graphs of their consumption so they can observe the progress made over time.

DAILY MONITORING FORM

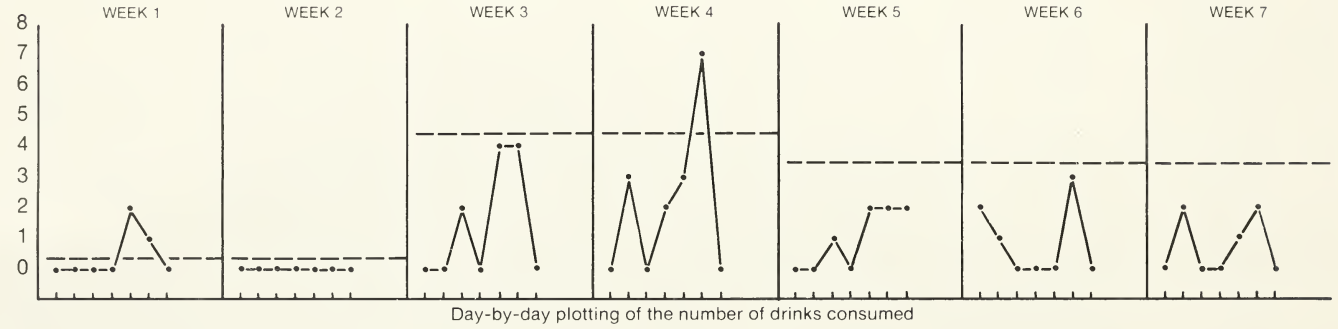
Goal
Max. no. drinks/day: ____
Max. no. days/week: ____

Actual record:
No. Abstinent Days ____
No. Drinking Days ____
No. Drinks Taken ____

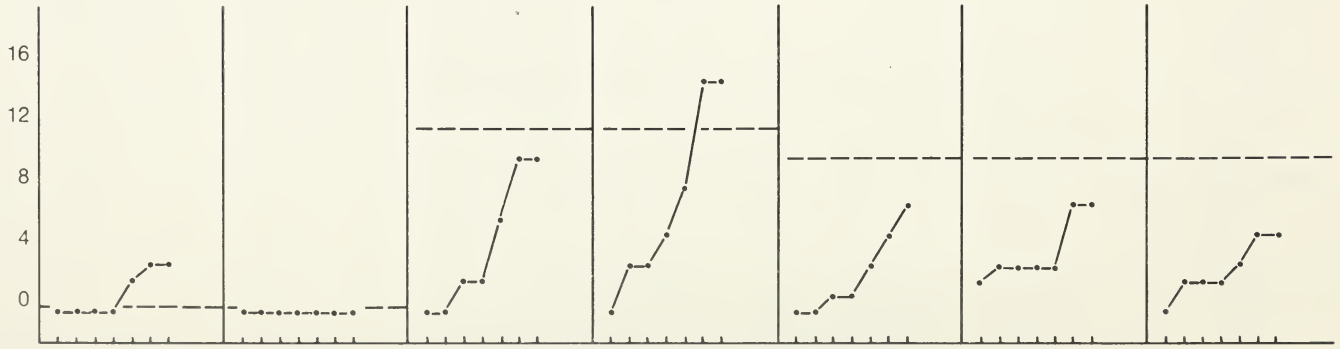
DATES							
Bottles of beer							
Glasses of wine							
Glasses of sherry or other aperitif							
Shots of liquor							
TOTAL NO. OF DRINKS*							
How many of these drinks did you have before 12 noon?							

***One drink = 12 oz of beer 5%; 5 oz of wine 12%; 3 oz of fortified wine 20%; 1.5 oz of liquor 40%**

Graphs for a client who accepted two weeks of abstinence before initiating training in moderate drinking.



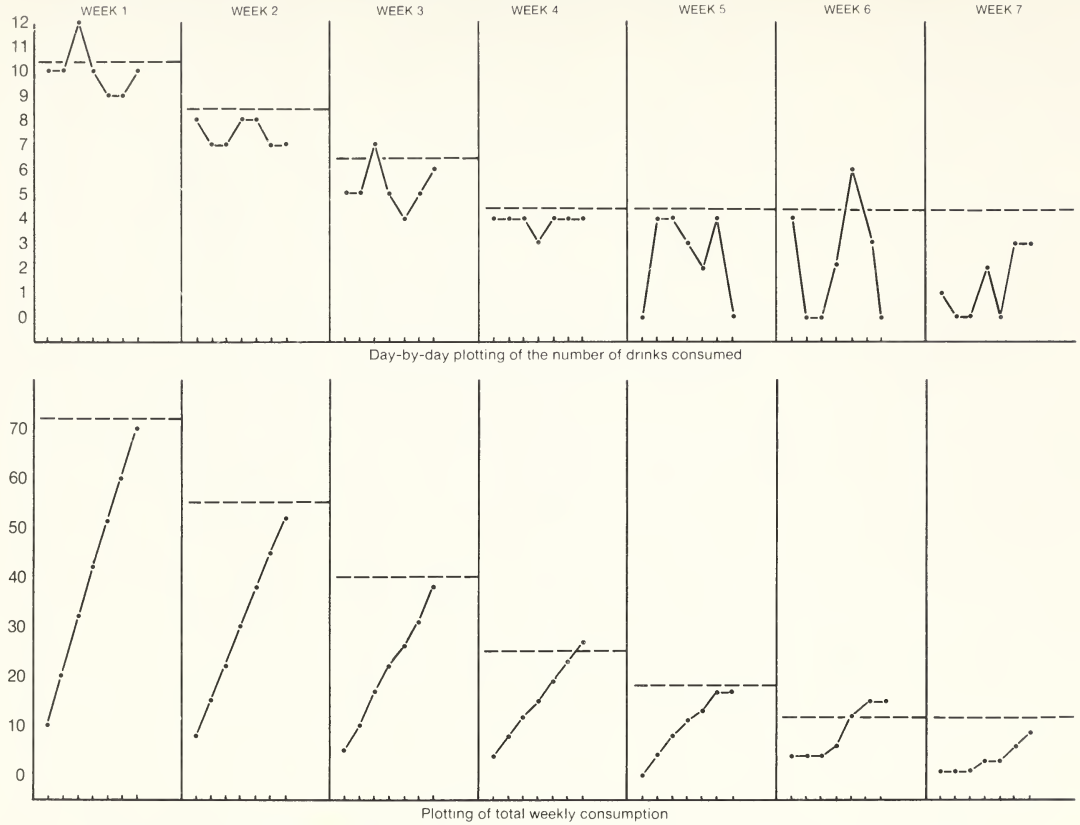
Day-by-day plotting of the number of drinks consumed



Plotting of total weekly consumption

In these cases, day-by-day plotting usually provides a better visual representation of the behavior, than plotting of total weekly quantity.

Graphs for a client who drank daily about 12 drinks, and who preferred to taper-off drinking. (The broken line indicates the upper limit negotiated with the client in number of drinks per drinking day, and in weekly quantity.)



In tapering-off, the plotting of total weekly consumption usually provides a better visual representation of the process of cutting down, than the day-by-day plotting.

IDENTIFICATION OF RISK SITUATIONS AND EXISTING COMPETENCIES

People who have problems with alcohol do not always drink in ways that give them problems; often they drink in ways that are totally appropriate. It is extremely important, therefore, that the therapist obtain information about the different situations in which problem drinking and problem-free drinking tend to occur. This information is crucial—both to formulate an appropriate drinking plan and to identify "risk" situations (i.e., those for which coping strategies are necessary).

Risk situations can be placed into two groups:

1. Situations where drinking has been a problem in the past (e.g., when feeling depressed or anxious).
2. Situations that tend to arise when the person decides to abstain or to reduce drinking (i.e., temptations to break the drinking rules, difficulty in refusing unwanted invitations to drink, and relapses).

To identify the two types of risk situations, we make use of two questionnaires, one called *Analysis of Function* (on pages 26 to 29), and the second called *Successful Coping with Urges to Drink and Social Pressures* (on page 30). This second questionnaire also serves to identify competencies that the client may have already to deal with the temptations to break the drinking rules and with unwanted invitations to drink. Before we describe these questionnaires and the manner of application, we will define what we mean by problem and problem-free drinking situations:

Problem drinking situations are those which result in short-term negative consequences (e.g., hangover, problems at home or at work, inappropriate behavior such as verbal aggression). They are also those situations in which people consume "hazardous" amounts of alcohol with no apparent short-term negative consequences. If such hazardous amounts are regularly consumed, however, they may eventually produce long-term negative consequences (e.g., impaired cognitive functioning, liver disease).

Problem-free drinking situations are those in which short-term negative consequences do not result. Consumption, even on a regular basis, remains below the hazardous level.

Long-term consumption of four standard drinks per day is generally accepted as constituting hazardous drinking, although lower levels are probably not without health risks (Popham & Schmidt, 1978).

Analysis of Function Questionnaire

This questionnaire was developed in collaboration with D.A. Wilkinson of the Addiction Research Foundation's Clinical Institute. It consists of three sections. The first is mainly designed to identify the *functions* attri-

buted to alcohol in situations where drinking has been a problem and in those where drinking has been problem-free. The second section is used to specify the *antecedents* and *consequences* of problem-drinking situations. In the third section the therapist can make a summary statement regarding *risk situations* and *coping strategies* that the client needs to develop.

The six categories included in the questionnaire were abstracted from 297 descriptions of incidents of problem drinking obtained from the 70 clients who participated in our preventive study. These descriptions were examined by two raters, who allocated responses to the six categories in the questionnaire with acceptable reliability (81% concordance). The proportion of descriptions that fell within each category is as follows:

1.	To attenuate negative feelings or emotions	42.1%
2.	To have pleasure	33.0%
3.	To aid performance of some kind	15.8%
4.	To reduce social pressures, or to be part of the crowd	2.4%
5.	To medicate oneself	2.3%
6.	Habitual drinking, i.e., for no particularly identified purpose	4.4%

Some of the descriptions were ambiguous. For example, when drinking was depicted as "habitual," it was difficult to disentangle whether the client drank because of social pressures or because of the pleasure derived.

Descriptions of the consequences of the first few drinks indicated that they reliably had the positive effects that clients had anticipated (e.g., they felt less anxious or depressed, became more assertive or confident). However, the consequences of continued drinking were also reliably described as negative (e.g., hangover, missed work, quarrels).

Situations where alcohol was used for coping were most frequently of a social nature. The negative emotions were associated with ongoing conflicts with significant others (e.g., spouse, children, friends, work supervisors), or with the loss of a loved one by death, separation, or divorce. Although clients frequently reported that their drinking was preceded by a conscious decision, typically they did not consider alternative ways of coping. Thus, drinking as behavioral coping was a well-established response in this group of clients.

The procedures for the application of the questionnaire are given in the following sections.

First Section: Identifying the Functions Attributed to Alcohol in Problem and Problem-Free Drinking Situations

Explain to the client that the six types of situations in the questionnaire were abstracted from numerous descriptions that clients have given of problem and problem-free drinking situations. Define problem and problem-free drinking situations (see page 20); then, ask the client to indicate for

each of the six types of situations whether, in the previous three months, drinking has been a problem or not, or if drinking never occurred. Subsequently, instruct the client to *rank* the types of problem-drinking situations according to their relative frequency by assigning No. 1 to the situation that occurred most frequently, No. 2 to the situation following, and so on. Once this task has been completed, tell the client that the information regarding situations where drinking was not a problem will be used later on, when the plan for moderate drinking is formulated.

Second Section: Specifying Incidents of Problem Drinking

The second stage of the Analysis of Function is the precise description of particular incidents of problem drinking. As a first exercise ask the client to describe an incident representing the function of drinking ranked highest in the previous section. An adequate description of these events should include the *antecedents* of drinking (which are used to recognize risk situations more accurately), the *immediate consequences* (which are used to assess the validity of the function(s) attributed to drinking), and the *delayed consequences* (which tend to be the consequences that differentiate problem from problem-free drinking).

In describing the *antecedents* of drinking the client is asked to outline the sequence of events that resulted in drinking and to answer the following questions:

- Where were you and with whom when you decided to drink?
- What were you feeling at the time?
- Were you preoccupied by anything?
- What did you expect alcohol or drinking to do for you in that situation?

The *immediate consequences* of drinking refer to changes that occurred in behavior, emotional experiences, or social environment after the first few drinks. Frequently, these consequences reveal the reinforcing properties of alcohol consumption for the client.

The *delayed consequences* of drinking are the effects of continued drinking on the client's emotions, physical condition, and social, vocational, and legal transactions. These consequences are usually the ones that clients focus upon when they regard drinking as a problem. In some instances, however, the reinforcers of drinking may be listed in this section. For example, the client may list verbal or physical aggression as a delayed negative consequence of drinking; this aggression may be a problem for other people, but it may also be perceived by the client as one of the benefits of drinking.

When the antecedents, contexts, and consequences of drinking have been specified, the therapist and client together make a final appraisal of the drinking incident. If the functions of drinking appear *inconsistent* with the

reasons the client gives for drinking, this is noted, and the probable function is specified. For example, if the client said that he drank in order to increase assertiveness so that he could ask someone to dance, and after a few drinks did, in fact, manage to do so, we could say that the function attributed to alcohol and the immediate consequences are congruent. On the other hand, if the client did not get around to asking someone to dance, but became verbally aggressive towards his drinking partners, then the function he attributed to alcohol and the immediate consequences of drinking are not congruent.

Guide clients to specify drinking incidents as concretely as possible. Generally, they have difficulty in being specific. It may therefore be necessary to specify several incidents in this way before the client can supply succinct and concrete descriptions. Once the client understands how problem-drinking situations should be specified, stress the value of the exercise by saying, "If you want to become successful in moderating your drinking (or in abstaining), you should take this exercise very seriously. The more you are able to specify the situations in which your drinking has been a problem, the better off you will be. When you examine the fine details of your problem drinking, you can discover the cues that trigger it, and therefore learn to cope."

Homework Assignment

Ask the client to specify incidents of problem drinking. For the initial assignment, recommend that specifications be made of incidents corresponding to the types of situations ranked with the highest frequency.

Also recommend that the client specify incidents that he or she remembers well. In specifying incidents the client should concentrate on the details of each particular incident, not on what is generally the case.

During the Preparatory Phase, our clients tend to produce from four to six specifications of problem-drinking incidents. It is difficult to advise therapists regarding the number of specifications that they should request from their clients. We can suggest, however, that in making a judgment you take into account the following factors: (a) the frequency of heavy or hazardous drinking (categories 5–9 and 10+ drinks) reported in the Alcohol Consumption Questionnaire; and (b) the extent to which drinking has been habitual, restricted to a specific situation, or generalized to a number of situations. When problem drinking is habitual or restricted to a given set of conditions, clients often produce only a single specification. In such cases, they say with certainty: "All my heavy drinking occurs only when . . . The rest of the time alcohol is not a problem." Then there is no reason to

demand more specifications; inquire only about the frequency of the particular event. If problem drinking has occurred in a variety of situations, it may be difficult to make a judgment regarding the number of specifications to request from the client. Two or three specifications for each type of problem situation will probably yield sufficient information.

The Therapist's Use of This Information. For each problem-drinking situation specified, first ensure that it has been adequately described. Then examine the consequences of drinking (particularly the immediate consequences) to check the congruence with the function(s) attributed to alcohol. If the consequences of drinking are incongruent, explore the six types of situations described in the first section of the questionnaire with the client to determine which function is most closely associated with the present incident. Further, for each situation specified, you may ask the client to imagine that he or she is back in the situation and to think of responses that could have been useful to forestall excessive drinking (i.e., what the client could have *done* or *said to him / herself* to prevent excessive drinking).

Third Section: Identifying Risk Situations and Required Coping Skills

In this section of the questionnaire the therapist makes a summary statement of all the risk situations and the coping skills required by the client. In other words, you should record the specific functions that the client has attributed to alcohol when drinking was a problem, and the coping skills that need to be developed. For example, if the functions attributed to alcohol were to reduce feelings of boredom, and to express anger to the spouse and to the supervisor, the client should be helped to plan activities to relieve the boredom, and to learn how to express anger constructively.

This section is left open-ended, so that you can make your own interpretations of the client's reports. These interpretations can then be checked with someone experienced in making analyses of function, until you have proficiency in the process.

An example of a completed Analysis of Function Questionnaire can be found in Appendix A.

Successful Coping with Urges to Drink and Social Pressures

This questionnaire (see page 30) is designed to identify situations where the client succeeds in resisting urges or temptations to go over the established limits, which may mean either abstinence or moderate drinking. Space is provided for a brief description of the situation (i.e., place, companions, the client's emotions, and cognitive and behavioral ways of coping).

The questionnaire also provides space for a short description of situations where the client coped successfully with pressures from others to drink (i.e., the locale, the host, what the client said and did).

In the evaluation of the program the 70 clients described 180 incidents of successfully coping with urges to drink and social pressures. The

circumstances of successful coping reported are as follows:

1. Where clients experienced negative emotions or an interpersonal conflict	40.0%
2. Where alcohol was available, or where clients were invited to drink	33.9%
3. Where clients experienced positive feelings, and wished to enjoy the taste or the effects of alcohol	13.3%
4. Where drinking was previously habitual	12.8%

It is interesting to note that negative emotions were preeminent among coping situations, as they had been in pretreatment problem drinking. Clients had been advised that one risk situation likely to arise as a result of the decision to abstain or to reduce drinking might be a strong temptation to defy their drinking rules or to yield to social pressures to drink. Although problem drinking under these circumstances was rarely identified as preceding treatment, the necessity of coping with social pressures to drink after the initiation of treatment was reported in about 34% of the coping incidents. There was also an almost threefold increase in the salience of situations in which drinking appeared to be purely habitual.

The identification of the situations in which the clients spontaneously coped during the initial stages of treatment does not indicate a *generalized* behavioral deficit in the group. However, some clients may have encountered difficulty in *particular* types of situations. The coping skills that are evident in clients before training in coping may provide an explanation of the speed with which the present treatment package can be generally delivered (six weekly sessions on average).

Self-statements that the clients reported using more frequently to forestall drinking had the following functions: (a) *remind oneself of the consequences of drinking or not drinking* (e.g., "If I drink now I'll feel worse later," "If I resist the urge I'll be proud of myself"); (b) *reappraise the situation or the role of alcohol* (e.g., "I don't need to drink to enjoy myself," "Drinking is not going to help my depression"); (c) *remind oneself about one's commitment to maintain abstinence or reduced drinking* (e.g., "I made a commitment to myself and I'll stick to it").

Behaviors more frequently reported by clients as an alternative to drinking were: (a) *consummatory behaviors* (e.g., consumption of non-alcoholic beverages and, to a lesser extent, eating and smoking); (b) *sedentary recreation* (e.g., watching TV, reading, listening to music, and going to movies); and (c) *active recreation or distracting activities* (e.g., physical exercise, working or studying, visiting friends, going shopping).

Cognitive coping was as extensively used as behavioral coping. In about 90% of the incidents described the clients reported at least one coping self-statement.

ANALYSIS OF FUNCTION QUESTIONNAIRE
(M. Sanchez-Craig and D.A. Wilkinson)

Drinkers attribute many functions to alcohol. We have identified six types of functions that heavy drinkers often attribute to alcohol. The purpose of this exercise is to recognize the functions that clients have attributed to alcohol when their drinking has been moderate and when it has been excessive.

For each one of the functions described below, please indicate whether in the past 3 months: drinking *never* occurred, or if it did occur, whether is was *problem-free*, *associated with problems*, or *both*. Subsequently, rank those situations in which drinking was associated with problems, according to their relative frequency (assign No. 1 to the most frequent, No. 2 to the one that follows, and so on).

	Drinking Never Occurred	Drinking Was Problem-Free	Drinking Was Associated with Problems	Rank
1. To relieve negative feelings or emotions (e.g., anxiety, depression, loneliness, fear, guilt, boredom, sadness, frustration, lack of confidence).	( )	( )	( )	( )
2. To help in doing something that would be less probable without drinking (e.g., express anger or affection, engage in sexual behavior, express opinions, complete tedious tasks, talk to strangers, dance).	( )	( )	( )	( )
3. To medicate oneself (e.g., to relieve physical pain, hangover, help sleep).	( )	( )	( )	( )

4. To reduce social pressures, or to be part of the crowd (e.g. when alcohol is freely available, when it is difficult to refuse invitations to drink).	( )	( )	( )	( )
5. To have pleasure (e.g., to enjoy the taste of a beverage or the effects of alcohol, to have fun with friends, to enhance meals, to quench thirst).	( )	( )	( )	( )
6. Drinking is habitual, for no particularly identified purpose (e.g., at the same time, in the same place, with the same people).	( )	( )	( )	( )
7. Other: _____	( )	( )	( )	( )

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SPECIFIC INCIDENTS OF PROBLEM DRINKING

Think first of the incident that you wish to describe, and then answer the following questions as concretely as possible:

1. *ANTECEDENTS*

Where were you and with whom when the *decision* to drink was made?_____

What were you feeling before you drank?_____

Were you preoccupied by anything?_____

What *function(s)*, if any, did you expect alcohol or drinking to serve in this situation?_____

2. *CONTEXT OF DRINKING*

Where were you and with whom when the *actual* drinking occurred?_____

3. *CONSEQUENCES*

Describe what happened after you consumed the first two or three drinks (e.g., became less anxious or angry, became more talkative or assertive, made more threats or sexual advances, felt happier).

Describe what happened with continued drinking (e.g., felt sick, guilty, depressed, passed out, got into a fight, spent too much money, missed work, was charged with impaired driving).

4. *FINAL APPRAISAL*

Did alcohol, or drinking, actually serve the expected functions in the particular incident? If not, specify:_____

IDENTIFICATION OF RISK SITUATIONS AND REQUIRED COPING SKILLS

1. Specify the principal risk situations, and the functions attributed to alcohol in these situations:

2. Specify how the client will cope in these situations. Identify particular cognitive and behavioral coping skills:

SUCCESSFUL COPING WITH URGES TO DRINK AND SOCIAL PRESSURES

URGES/TEMPTATIONS	SOCIAL PRESSURES
Where and with whom:_____	Where:_____
Feelings:_____	Who invited:_____
Self-statements:_____	What did you say:_____
_____	_____
Behaviors:_____	What did you do:_____
Where and with whom:_____	Where:_____
Feelings:_____	Who invited:_____
Self-statements:_____	What did you say:_____
_____	_____
Behaviors:_____	What did you do:_____
Where and with whom:_____	Where:_____
Feelings:_____	Who invited:_____
Self-statements:_____	What did you say:_____
_____	_____
Behaviors:_____	What did you do:_____

The client is introduced to the Successful Coping questionnaire with the following rationale:

> When heavy drinkers abstain or cut down on their drinking, they usually experience two sorts of difficulties: their own urges or temptations to drink and the pressures from others. We think that before you begin training in moderation, it is extremely desirable to study how you cope in these sorts of situations. If you can identify coping responses which you naturally use, and of which you may not be aware, you can save a significant amount of time and effort in achieving your goal.

Make sure clients realize they can cope in difficult situations, by both cognitive and behavioral means. Explain that cognitive coping consists of "internal dialogues" (self-statements) or things that one says to oneself in order to counteract rationalizations to drink.

Ask clients to record their statements, and to be as specific as possible regarding their feelings. For example, instead of such vague terms as "upset" or "uptight," more specific descriptions (such as "afraid," "frustrated," or "angry") are expected.

Stress, again, the value of identifying coping responses that already exist, of which the client may not be aware.

Homework Assignment

Ask clients who have decided to abstain to specify the situations in which they coped successfully with strong urges to drink, and the situations in which they were able to resist social pressures.

Ask clients who have decided to taper off to specify situations in which they coped successfully with temptations to break their drinking rule, and situations in which, having reached the day's limit, additional drinks were refused.

Clients should continue to keep a record of these situations until procedures for problem-solving described in the Acquisition Phase of the program (i.e., the next phase) are introduced.

The Therapist's Use of This Information. As the client describes situations, first ensure that each one has been properly specified. Then discuss the coping responses used in each case, and ask the client to comment on their effectiveness and appropriateness. These exercises are extremely important since clients not only become aware of their competencies but also begin to practice analyzing coping responses. Such analysis will be a crucial component of the problem-solving strategies that clients will learn during the Acquisition Phase of the program.

Examples provided by clients in this questionnaire can be found in Appendix B.

ACQUISITION PHASE

This phase has the following components:

- Specification of the Long-Term Drinking Goal
- Guidelines for Moderate Drinking
- Aids for Moderate Drinking
- Problem-Solving Strategies
- Orientation to Problem Solving
- Termination of Treatment

SPECIFICATION OF THE LONG-TERM DRINKING GOAL

Should the long-term goal be abstinence or moderate drinking?

After the Preparatory Phase, it is important to reassess the treatment goal. Information gathered during this phase may suggest that the goal the client initially had in mind is neither desirable nor advisable.

- Some clients who initially request to learn how to moderate their alcohol use decide, after the initial period of abstinence, that they wish to continue maintaining abstinence. A female client of ours, for example, indicated that she was extremely happy about the effects of the three weeks of abstinence (she had lost some weight, looked healthier, and had more energy). Her friends were heavy drinkers, and their admiration of her achievement was particularly reinforcing. The way she put it was, "I am not ready to give all these things up." After four months of abstinence, however, she decided that she wanted to reintroduce limited drinking into her life.
- Some clients who initially request abstinence discover during the Preparatory Phase that, under certain circumstances (e.g., family gatherings, when feeling relaxed), they manage to drink limited amounts without any problem. They then decide that moderation is a more desirable goal for them.
- Some clients who resist maintaining an initial period of abstinence adopt a cautious attitude, and agree to reduce their drinking by only a small amount at a time (e.g., one drink per day). If they consistently reduce their drinking by these small amounts, they usually succeed in achieving moderation or abstinence. Some, however, fail to do so; in such cases, the goal of treatment should be discussed again to establish whether abstinence may be more appropriate, or whether the client is really interested in doing something about his or her drinking at the present time. Therapist and client may then decide: (a) to try moderation again for a specified period of time (e.g., one month), (b) to shift to an abstinence goal, or (c) to postpone treatment.

GUIDELINES FOR MODERATE DRINKING

Among our clients, those who have been successful in achieving moderate alcohol use tend to adopt the following guidelines:

- Do not drink daily.
- Drink no more than 4 drinks on drinking days.
- Drink no more than 20 drinks per week.

Note that some clients who drink 20 or fewer drinks per week report some problems associated with their drinking (e.g., missed work or meals, quarrels), and that the most successful clients drink no more than 12 drinks per week.

Explain to the client that a *suitable* and *safe* drinking pattern is one that fits well into an existing lifestyle and does not interfere with health or important responsibilities at work or home.

In setting a drinking goal, the following should be specified:

- The maximum number of drinking days per week.
- The maximum number of drinks to be consumed on drinking days.
- The type of beverages to be consumed.
- When it is appropriate to drink.
- When it is inappropriate to drink.
- Time for evaluating the specified goal (e.g., two weeks).

Situations when it is *appropriate* to drink are those in which drinking was not associated with problems in the *Analysis of Function Questionnaire*. Situations when it is *inappropriate* to drink are those identified as risk situations in the questionnaire.

Once the drinking goal and the conditions for drinking are specified, confirm the client's confidence about maintaining such a drinking regime by using the four-point scale described on page 13. You should reestablish the confidence rating each time a new drinking goal is set.

Stress the point that clients differ greatly in their ability to cope with the effects of alcohol, and that it is extremely important to assess whether the specified goal interferes in any way with important aspects of the client's life (e.g., job and family responsibilities, close friendships). Point out the fact that some clients drinking amounts that may be regarded as moderate by common standards (i.e., no more than 20 drinks per week) report that alcohol gives them problems (Sanchez-Craig et al., 1984).

Homework Assignment

Request that the client note any problems arising from the specified drinking regime, so that appropriate adjustments can be made to the goal.

AIDS FOR MODERATE DRINKING

These include:

- Self-monitoring of drinking behavior.
- Pacing drinking.
- Preparing in advance to avoid heavy drinking.
- Developing activities incompatible with heavy drinking.

Self-Monitoring of Drinking Behavior

Instruct the client to keep using the self-monitoring form for daily records of drinking behavior. If "serious" violations of the drinking rules occur, the antecedents and consequences of those drinking episodes should be described as in the second section of the *Analysis of Function Questionnaire*. This specification will increase the client's understanding of the cues that trigger inappropriate drinking, and suggest where coping strategies must be strengthened or developed.

Pacing Drinking

Advise the client of the documented differences between the drinking behavior of alcoholics and social drinkers. These differences relate to the manner in which members of the two groups pace themselves while drinking. Whereas alcoholics tend to consume straight drinks and to gulp them, social drinkers tend to consume mixed drinks and to sip them (Schaefer et al., 1978). Also, whereas social drinkers tend to measure their drinks, alcoholics do not. Stress the importance of developing pacing skills, and instruct the client to *measure* each drink, to *dilute* drinks (avoiding carbonated beverages since these increase the rate of alcohol absorption), to *sip* drinks, and to *space* them (e.g., by waiting at least one hour before taking the next drink, by alternating alcoholic and non-alcoholic beverages). Recommend that alcohol be ingested along with food, especially food with a high fat or protein content, since it delays the rate of alcohol absorption (Holt, 1981).

Preparation for Drinking Events

Explain to the client that while learning to drink moderately one cannot afford to behave spontaneously or impulsively. In order to increase the probability of moderation, one must prepare for drinking situations deliberately. This means that the client must decide in advance how many drinks will be taken, and plan supports for the strategy—e.g., by requesting help from the host, pouring one's own drinks, pacing drinking by alternating alcoholic and non-alcoholic beverages, and using mnemonic devices to avoid losing count of drinks consumed. The client must also anticipate

potential difficulties—e.g., temptations to defy the rules, pressures from others to drink, emotional upset in the course of the social event—and prepare coping responses to use if such difficulties arose.

Prepare the client for drinking events by discussing, in the terms outlined above, those situations in which drinking is planned in the near future.

Developing Activities Incompatible with Heavy Drinking

Stress the importance of developing activities that are incompatible with drinking, to fill the times when the client used to drink heavily. Examples of such activities include engaging in educational or physical fitness programs, developing or reactivating hobbies, and modifying the social network to be more supportive of the client's goal.

Remind the client that often those who fail to moderate their drinking have not managed to fill the *vacuum* left in their days with other enjoyable activities. When clients have difficulty in developing such activities, consider a referral to a recreational or vocational counselor.

Once the drinking goal and the aids for moderation have been specified, tell the client:

> The development of a moderate drinking pattern takes time, commitment, and self-discipline. Some people fail because they find it too difficult to follow rules and to act deliberately for prolonged periods of time. If you want to succeed, you must *persist* in the deliberate application of your drinking rules until they become second nature. This may take months. You must also persist in keeping track of your drinking behavior so that you will have objective evidence of your progress.

Then ask:

> Are you prepared to commit yourself to these activities?

PROBLEM-SOLVING STRATEGIES

In the context of treating excessive drinking, a problem is any obstacle that may interfere with achieving or maintaining the drinking goal. Obstacles that are likely to be identified during treatment tend to be of three general classes:

1. The need to deal with situations where drinking has been a problem in the past (i.e., the risk situations as identified by the Analysis of Function).
2. Difficulty in dealing with situations that tend to arise when drinking is discontinued or reduced (i.e., social pressures, temptations to break the drinking rules, and relapses).
3. Difficulty in developing activities that may be useful to maintain the changes in drinking patterns (e.g., new recreational habits) and to engender a reevaluation of the importance of alcohol.

We use three strategies to teach clients how to cope effectively with risk situations, and how to develop activities or habits that help them maintain moderation or abstinence. Since the incidents of problem drinking and risk situations are most frequently associated with negative emotions and interpersonal conflicts, two of the strategies are specifically designed to deal with these kinds of problems. The *Strategy for Interpersonal Problems* emphasizes the development of *behavioral coping*, designed to produce immediate and direct changes in the social environment and to forestall the old coping response of drinking. The *Strategy for Negative Emotions* emphasizes the development of *cognitive coping*, designed to palliate the negative emotions and to set the emotional tone required for initiating activities that will compete with the disruptive emotions and excessive drinking. The third strategy–*Strategy for Attainment of Longer-Term Goals*–is more general in nature. It is designed to help clients in the development of activities, or habits, that may be required to maintain the gains of treatment over the longer term. Through these strategies we attempt to develop in clients the practice of approaching problems, or new goals, in an objective manner, of entertaining a variety of options, and of assessing systematically the effectiveness of selected options.

The steps in our problem-solving strategies are similar to those employed by D'Zurilla and Goldfried (1971) for training clients to cope with problematic situations. In exploring alternative ways of coping however, these authors consider *only* behavioral options. Our strategies also involve cognitive coping, either as a means of facilitating behavioral coping or as an alternative response in its own right. The specific classes of solutions we recommend in problem solving are influenced by the work of Lazarus (1974, 1980), who distinguishes two main functions of coping. One is to "*act instrumentally*" so as to change a situation for the better. The person may, for

example, act directly on the self or the social environment to eliminate danger or to increase gratification. We term this behavioral coping. The second function of coping is to "*regulate the distressing emotion itself*" through cognitive processes. In this manner, the person may attenuate the negative emotion without changing the stimulus situation. For example, the person may reappraise an aversive situation as being more benign, or may tune out thinking about it, or may deny that it ever happened, or may learn to tolerate it. This activity, thought of as cognitive coping, is particularly relevant in dealing with situations in which there is little or nothing that the person can do to change them (e.g., the death of a loved one, terminal illness). Note that in dividing coping into two principal modes of expression Lazarus is not proposing that actions and thoughts are mutually exclusive. He considers them interactive.

Cognitive and behavioral coping can be effective or ineffective and, independently, can be adaptive or maladaptive. For example, drinking as behavioral coping is generally appraised by problem drinkers as effective, in that it successfully attenuates whatever threat or discomfort is being experienced. However, if drinking results in adverse consequences, it becomes maladaptive. Similarly, cognitive coping (e.g., denial) may be effective if it mitigates aversive emotions, but if it prevents one from taking actions that may be necessary for good functioning, it becomes maladaptive.

Before we get into the specifics of the three problem-solving strategies, it is useful to describe their common logical structure. Each strategy includes the following six steps, though the emphasis on each step may vary between strategies:

1. Identifying the Problem

To find a satisfactory solution to the problem, it is critical to recognize both the nature of the problem and the specific details of the various aspects of the problem. Identifying the nature of the problem consists in rendering the client's general statements of dissatisfaction more specific, by means of questions. The nature of the problem is identified when the most appropriate strategy or strategies for dealing with the problem are revealed by this identification. A client, for example, may express dissatisfaction about his job by saying to the therapist, "I hate my job." Through this statement, the client could mean: (a) That although he liked his job, recent conflicts with the supervisor have made the job very stressful. In this case the Strategy for Interpersonal Problems would be appropriate. (b) That the job itself is dreary and unstimulating, and the client would like to explore alternatives. In this case the Strategy for Attainment of Longer-Term Goals is indicated. (c) That the job is a necessity because he has to support his children, and cannot afford to do what he really wants (go back to school). Since the client cannot alter the situation in the immediate future, the Strategy for Negative Emotions would be appropriate to help him reappraise the situation.

Specifying the problem consists in eliciting from the client concrete descriptions about the various aspects of the problem situation. These include: (a) the aversive stimuli (these could be certain environmental conditions, what somebody does, what the client does or feels, or behavioral deficits in the client); (b) the client's interpretations of the aversive stimuli; (c) the client's emotional reactions; (d) the approaches that the client has used in the past to handle the problem situation; and (e) the consequences of the client's approaches for self and others.

2. Considering Alternative Interpretations

We propose that appraisals or interpretations of events significantly influence how we feel and behave. In solving a problem, therefore, it is important to assess the validity of the client's interpretations of the problem situation. This process consists in exploring with the client whether his or her current interpretations are realistic or accurate. It is important to make the client aware of the fact that a single event can always be interpreted in more than one way. Alternative interpretations of negative situations can be elicited with regard both to the stimuli themselves (e.g., what somebody does, feelings of depression or guilt, a monotonous job) and to the client's responses in the situation: How else can the client interpret the aversive clues? How else can the client interpret his or her own reactions to those cues?

In descriptions that our clients have made of incidents of problem drinking, their interpretations of the situations are often negative, narrow, self-defeating, and even catastrophic. For example, after a relapse a client may say, "I'll never make it, it is useless to try!" or, after a separation from his wife, a client may say, "My wife has rejected me, I'll be alone for the rest of my life." It is important to urge the client to produce as many interpretations of the problem situation as possible, even if at first glance some would appear to be a little crazy. The aim is to make the client's thinking more flexible, and to promote the practice of considering that more than one interpretation might be correct.

3. Formulating Cognitive and Behavioral Coping

Although the problem-solving strategies are designed to promote both forms of coping, depending on the nature of the problem at hand, cognitive or behavioral coping may become the initial or primary form of response. Formulating coping responses consists in translating the client's *new* interpretations of the problem situation into specific self-statements and behaviors that could help to relieve the negative emotions and/or to change the situation for the better. To achieve this aim, we ask the client to consider each new interpretation, assuming that it is accurate, and then to specify if any self-statements or behaviors logically or naturally follow from that line of thinking. The aim is to make the client realize that different ways of

thinking lead to different ways of handling the problem. We believe that this method helps the client to formulate coping responses more readily.

Once the decision to stop or to moderate drinking is made, the tendency to drink inappropriately in the presence of situational cues will persist. Cognitive coping is extremely useful to override this tendency and to motivate alternative actions. In situations of relapse, cognitive coping is also extremely useful to counteract the negative thoughts and emotions typically associated with relapse (see Marlatt & Gordon, 1980), and to prevent the client from giving up his or her drinking goal. Often clients report that in situations where they would not expect it, "out of the blue" they experience strong urges to drink. Cognitive coping is the most immediately available response to deal with these emergencies.

4. Selecting the Most Promising Coping Responses

Selecting the coping responses likely to produce the most desirable results consists of two components: asking the client to anticipate the possible consequences of each response; and asking the client to assess his or her ability to perform the response. Whether the intended response is cognitive, behavioral, or both, we ask the client to imagine the probable impact of the response: How would the client feel after implementing it? Will the response prevent his or her drinking? Will it give the client a greater sense of control over the situation? How will other parties to the interaction respond? If a response is selected, surely the response to these questions must be favorable. Next we ask the client if he or she anticipates any difficulty in carrying through the response. If a response is selected that the client perceives as potentially difficult, adjustments should be made to the response until the client expresses confidence about implementing it in the risk situation. We find that effective coping responses are often simple, straightforward, and minimally disruptive of other activities.

5. Rehearsing Selected Coping Responses

This is the process whereby the client is given an opportunity to practice new coping responses in the presence of the therapist. The method of rehearsal may be behavioral (e.g., role playing) or cognitive (e.g., covert rehearsal). Our method has both cognitive and behavioral components: We ask the client to imagine the problem situation and to describe the scenes *aloud*, particularly those where the client is supposed to implement the new response. During rehearsal we direct the client's attention to a variety of aspects of the imagined situation. For example, in rehearsing a behavior to solve an interpersonal conflict, we ask the client to anticipate and describe the impact of the behavior on *X*, the client's feelings while carrying through the behavior, and the consequences for self and *X*. During these rehearsals the client may modify the coping responses in order to make them more effective.

We recommend this method mainly because clients can learn to rehearse coping responses on their own, using their imagination. We "sell" clients the advantages of rehearsing in imagination with the following rationale: Changing our thinking and behavior in deliberate ways requires practice, and a good way of practicing is by using our imagination. We use our imagination all the time for similar purposes. For example, before we speak to a stranger on the telephone we review in our mind what we are going to say. Rehearsing mentally has the advantage that we can do it in privacy, and for as long as we consider it necessary.

6. Implementing and Assessing Coping Responses

This process consists in instructing the client about the observations he or she must make to assess the effectiveness of a new coping response. We ask the client to implement the new response, as the opportunity arises, and to assess the outcome carefully by asking questions such as: Am I satisfied with the consequences of my new response? Did it make me feel more comfortable? Did it prevent me from drinking excessively? Did it produce the changes in *X* that I expected? Did I have any difficulty carrying it through? Can I do something to make it more effective? We tell the client that if the response does not produce the desired consequences, or if he or she cannot carry it through because of difficulties that were not anticipated, there is no point in getting discouraged. Some other solution can be discussed in the following session.

ORIENTATION TO PROBLEM SOLVING

In introducing clients to problem solving, remind them that the aim of the program is not so much to help in the solution of problems, but to teach them how to solve problems on their own. We offer them the following rationale:

> Having problems is part of being human; drinking excessively is not. The problems you have in the future may be quite different from those you have today. We believe that you will be better off if you learn how to solve problems of daily living on your own. To do that, we will use your own experiences; we will teach you how to apply problem-solving strategies to those situations where you have had difficulty with alcohol, or where you might be at risk of drinking inappropriately.

In applying the strategies ensure that clients learn the steps and their sequence. As an aid to learning give them the versions of the strategies on pages 48–49, 55–56, and 60–61, with the request that they study them on their own. You can *reinforce* the learning of the strategies while assisting the client to solve a particular problem. For example, in dealing with a problem of negative emotions, use the written version of this strategy and follow the sequence of steps with the client.

In this section we will describe the types of situations for which each strategy is most appropriate; also, we will illustrate the strategies with particular examples selected from our clinical practice.

STRATEGY FOR INTERPERSONAL PROBLEMS

Without any doubt, this strategy is the one we use most extensively in our counseling. Specifically, it is applied to the following situations:

1. Where clients have an ongoing conflict with significant others (e.g., spouse, close friend, work supervisor, co-worker), and immediate action is both possible and desirable.
2. Where clients have difficulty in refusing invitations to drink.

If clients have not identified difficulty in these areas, teach the strategy by using hypothetical examples, or by using problem situations that clients have already resolved successfully. Stress the importance of resolving interpersonal problems before they become destructive.

CASE 1: Wife–Husband Conflict

The client is 30 years of age, has been married for about three years, and has been in the same job, working as computer analyst, since he graduated from university. He requested treatment because he felt that his drinking was interfering with the performance of his work. The client's wife is also employed. Just after their marriage they agreed to have a combined savings account for the future purchase of a house. Some of the client's excessive drinking was associated with conflicts with his wife, on account of her disposing of their savings.

Specifying the Problem

To specify the various aspects of the problem we asked the client to describe, as concretely as possible, particular details of the problem situation, as follows:

—*What does your wife do that is upsetting?*
"My wife's sister is always short of money, and my wife keeps giving her some of our savings without consulting me."

—*How do you react when you find out? Let's talk specifically about how you feel, how you interpret what she does, and what you do.*
"I feel angry. My thinking is that she has no right to use our savings without consulting me, and that she must not be serious about us getting a house. Because I find it difficult to express my anger, I begin to drink."

—*What are the consequences of your reactions?*
"After three or four drinks I become verbally aggressive, which leads to quarreling with her. I continue to drink until getting drunk, and she stops talking to me for a couple of days. During this time I feel very guilty."

Considering Alternative Interpretations

We explained to the client that when we have problems with other people, we tend to interpret what they say or do in a particular way, usually negatively, which helps to maintain the conflict. Further, we explained that interpersonal problems can probably be solved more effectively if we learn to look at the problem situation in different ways, not only one. Then we asked the client the following two questions:

—*How else can you think about your wife's behavior?*
The client was able to produce the following reinterpretations: "Probably she goes behind my back because she knows that I dislike her sister. She may be afraid that I'll say no. She comes from a family where they like to help each other. This problem is caused by her sister who keeps asking for money."

—*Should you reinterpret what you do?*
The client concluded: "Although I think that my anger is legitimate, there is no need to express it the way I have. Drinking hasn't helped me to solve the problem."

Considering Alternative Behaviors

We informed the client of our belief that our interpretations of events are important influences on how we feel and behave. We then asked him to consider each of his new interpretations and to specify whether any action(s) would logically follow:

—*If you think in this new way about what your wife does, or about how you respond, what would you do?*
The client thought of the following behaviors: "I could tell my wife: 'What bothers me is not that you help your sister, but that you do it behind my back,' or 'Why don't you keep a specific sum to spend as you wish?' or 'Shall we keep separate savings accounts?' I could walk out of the house until I cool off. I could speak to her sister."

Selecting the Most Promising Coping Responses

To select from the above behaviors those most likely to produce desirable results, we asked the client to anticipate their probable consequences, as follows:

—*What is likely to happen if you act in this new way?*

—*Will it stop your wife from going behind your back?*

—*How would this change in your wife make you feel?*

—*Will you have the need to drink to cope?*

After examining the various behaviors, the client decided that two of the statements above (i.e., "What bothers me is not that you help your sister, but that you do it behind my back," and "Why don't you keep a specific sum to spend as you wish?") would be most likely to result in positive consequences. He concluded that he would have no difficulty in talking to his wife in those terms, and that she probably would like to have her own money to spend as she wished. He would not have to drink heavily to cope with his anger, and they could avoid disputes and grow closer.

Rehearsing the Coping Responses

We guided the client to rehearse the statements to his wife until he repeated them easily and felt confident that they would produce positive results and that he would be able to proceed as planned. He felt no need to modify the statements; he believed them to be specific and straightforward.

Implementing and Assessing Coping Responses

We instructed the client to implement the new behaviors, as the opportunity arose, and to observe the outcome carefully. He should ask himself the following questions:

—*Am I satisfied with the consequences of my behavior?*

—*Did I feel comfortable saying to my wife what I had to say?*

—*Was her response positive?*

—*Did I have any difficulty in making my statements?*

—*Did I feel like drinking?*

Before he left the office, we advised the client that if the approach failed, or if he encountered difficulties that had not been anticipated, he should not get discouraged. Some other solution could be discussed in the next session.

The client reported that he had been able to discuss the situation with his wife. He implemented his statements as planned, and the outcome was satisfactory. They agreed that she would keep one-third of her salary from the family account to use as she pleased.

CASE 2: Social Pressures to Drink

The client is a 27-year-old woman, single, and employed in the sales department of a large cosmetics company. She presented to treatment because her fiancé threatened to terminate their relationship if she did not change the amount of drinking she did. When they went to social gather-

ings, often she would get drunk, and this annoyed her fiancé. She also disliked making a fool of herself. Some of her excessive drinking occurred in recurrent social gatherings organized by the work supervisor, which everyone in the sales department was expected to attend.

In identifying the problem situation, the client reported that she has difficulty coping with the pressures from the supervisor, who keeps pestering her to drink. Usually, he says: "Drink, don't be a party pooper." "Everybody else is enjoying themselves, why can't you?" The client feels extremely anxious. Her typical appraisals are: "If I say no, he'll get angry." "If I tell him about my drinking problem, I may lose my job." "It's better to be one of the gang." Because she is unable to cope with the pressures, she usually ends up drinking too much. The following day she feels angry at herself and the supervisor. If the fiancé discovers what happened, they quarrel about the incident.

In asking the client to consider alternative interpretations, she said: "I'm not certain that my supervisor will get angry if I say no, other people have in the past." "Telling him about my drinking probably will put my job in jeopardy." "You are meant to be part of a team, but you don't have to drink too much to be part of the team . . . *X* and *Y* go to the parties, but they drink little."

After considering her new interpretations, the client felt that the following statements could help her to cope with the pressures from the supervisor without feeling afraid: "I do not want a drink right now, I'll get one later," or "I would rather not have any more drinks tonight," or "I've reached my limit for tonight, and would rather have orange juice." The client also thought that pouring herself an orange juice on the rocks when the supervisor was not looking could discourage him from pushing her to drink. She also felt that if the supervisor got angry because she was not drinking, she could tell herself "It's his problem."

The client was guided to rehearse the above responses until she felt confident that she could carry them through, if necessary. At the next gathering, the client had the opportunity to implement the responses. She reported that, at first, they were ineffectual since the supervisor kept insisting that she drink. But finally, after continuing to assert herself, the frustrated supervisor gave up. At subsequent events she was able to maintain moderation. She had decided that three was the maximum number of drinks that she would consume on these occasions.

STRATEGY FOR INTERPERSONAL PROBLEMS

If you are upset about the way in which someone behaves towards you, and you think that correcting the situation is important, this strategy should be helpful. Also, the strategy should be helpful in helping you refuse invitations to drink without feeling afraid, guilty, or antisocial. Carefully follow this sequence of steps:

1. *Identify the Problem*. To solve interpersonal problems effectively, you must first recognize the relevant features of the problem situation. To do this, ask yourself the following questions:

   - What does *X* say or do that affects me adversely?
   - What do I think, or say to myself, when *X* behaves this way?
   - What do I usually do to handle the situation?
   - What have been the consequences of this conflict for myself and others?

2. *Consider New Ways of Thinking*. We propose that the way we think importantly influences how we feel and behave. Changing our thinking about what someone says or does, or about our own reactions in the situation, often helps to resolve the conflict. Remember that a single event can always be interpreted in more than one way. Ask yourself the following questions, and try to generate a number of new interpretations:

   - How else can I think about *X*'s behavior?
   - How else can I think about my own reactions? (e.g., am I overreacting?)

3. *Consider New Approaches*. If our thinking influences the way we behave, then each of your new interpretations of the problem situation should suggest a different way of approaching it. Consider each of these interpretations, and ask yourself the following questions:

   - If I think in this new way about *X*'s behavior, how would I handle the situation?
   - If I think in this new way about my own reactions in the situation, how would I handle it?

   Remember that approaches that work are often simple and straightforward.

4. *Select the Most Promising Approach*. To select the approach likely to produce the most desirable results, you must try to anticipate both its

probable impact and whether you can carry it through. For each of the potential approaches, ask yourself the following questions:

- How is *X* likely to respond if I behave this way?
- Will this approach give me a greater sense of control?
- Will I have difficulty in implementing it?
- Should I change the approach in some way to make it more effective?

5. *Rehearse the Selected Approach*. Before implementing your new approach, practice it in your mind until you feel confident. Feeling confident means that you can anticipate not only that your approach is likely to produce positive results but that you are able to carry it through. If you find it awkward to rehearse mentally, ask someone you trust to be a sounding board. While rehearsing modify your approach, if necessary, to make it more effective.

6. *Assess the Effectiveness of the Selected Approach*. To assess the effectiveness of your new approach, ask yourself the following questions:

   - Did I obtain the results I had anticipated?
   - What difficulties did I encounter?
   - Can I do something to make my approach more effective?
   - Do I have to develop another approach?

   If your approach did not work, or if you could not implement it, don't get discouraged. Try again. There will always be a variety of solutions to any problem.

STRATEGY FOR NEGATIVE EMOTIONS

This strategy is applied in the following situations:

1. Where clients feel depressed, anxious, angry, guilty, etc., and there is little or nothing they can do to change the situation (e.g., losing a loved one by death, divorce, or separation; being dismissed from a meaningful job because the company went broke; becoming handicapped; injuring someone while intoxicated).
2. Where clients are tempted to break the drinking rules.
3. Where clients relapse into the old drinking patterns and are tempted to abandon their drinking goal.
4. Where clients experience *unexpected* urges to drink inappropriately.

The coping responses that this strategy attempts to develop are primarily cognitive, that is, they take the form of self-statements that serve the following functions:

1. Inhibit the immediate tendency to drink in response to negative emotions (e.g., "Stop and think before you act").
2. Reappraise the aversiveness of the emotions and the role of alcohol (e.g., "Being depressed is not really harmful, but drinking to cope with my depression may worsen the problem").
3. Consider the consequences of drinking or not drinking (e.g., "If I don't drink now I'll feel proud of myself," "If I begin to drink I'll soon be back where I started").
4. Remind oneself of past achievements (e.g., "In the past I have been able to cope with worse feelings without drinking").
5. Motivate oneself for alternative actions (e.g., "What else can I do instead of drinking to make myself feel better?").

The behavioral coping that one hopes would be motivated by the cognitive coping may range in degree of complexity, and may or may not be within the client's behavioral repertoire. Early-stage problem drinkers usually have preestablished interests, recreational habits, or skills that can help them forestall the old coping response of drinking. With some planning and some effort on their part, these clients can readily engage in these activities. Sometimes, however, they have deficits in important areas (e.g., leisure), or their negative emotional states are associated with serious dissatisfaction (e.g., vocational, marital) that can be resolved only if they make *substantial* changes in their life. The Strategy for the Attainment of

Longer-Term Goals described below can be useful to clients in making these changes, but the assistance of specialized professionals may be required.

CASE 1: Feelings of Depression

The client is a 52-year-old senior executive of a food company. He is married, with two children not living at home. In the past 10 years his wife has been under continuous medical care, and for the past three months she has been in a psychiatric hospital, where she is expected to remain for an unspecified period of time. The client visits her on weekends. He requested treatment because during the months that his wife has been hospitalized he has been depressed, and his depression has caused him to drink to the extent of affecting his work.

Specifying the Problem

To specify the problem we asked the client to describe, as concretely as possible, particular details of the problem situation, as follows:

—*Can you describe what happens when you feel most depressed?*
"After work I come straight home, and immediately start to drink. Although the housekeeper prepares food for me, I eat little. I spend most of the evening sitting and drinking."

—*What do you say to yourself while you are drinking?*
"I'm lost without her. She'll never get well. Alcohol is the only thing that helps my depression. Nobody gives a damn."

—*What are the consequences of your drinking?*
"Usually I go to bed intoxicated, I wake up with a headache, and I forget things at work. Also, for the past three months I have stopped exercising and visiting my children, which I used to do regularly."

Considering Alternative Interpretations

We explained to the client that negative thoughts such as those he reported can seriously exacerbate feelings of depression, especially if one feels powerless to change the aversive situation. Further we explained that one can get out of the state of depression by more optimistic thoughts, provided that these are justified. Then we asked the client to consider each of his current self-statements to determine whether there were more accurate ways of looking at the situation:

—*To what extent is that way of thinking realistic or accurate?*
The client was able to produce the following reinterpretations: "I'm lost without her, but she is more lost without me. I cannot say that she'll never get well. She had a similar episode 10 years ago and recovered. Most people in my situation would get depressed, but wouldn't necessarily be driven to drink. My children and my sister care."

Considering Coping Self-Statements and Behaviors

We reminded the client of our belief that our thoughts importantly influence how we feel and behave. We then asked him to consider his new interpretations, and then to specify coping self-statements and behaviors, as follows:

—*If you think in this new way, what would you say to yourself to relieve your depression, and to avoid drinking heavily?*
The client formulated the following self-statements: "I'm not that helpless without her. I have a good reason to feel depressed, but drinking won't help. If I talk to my children, I'll probably feel better. If I keep myself busy, I'll probably feel better."

—*If you talk to yourself in these new ways, would you do something to make yourself feel better?*
The client thought of the following behaviors: "I could go swimming every day after work, the way I used to. I could visit my children and my sister once per week. I could take in a movie once in a while. I could shop for gifts to take to my wife."

Selecting the Most Promising Coping Responses

From the above self-statements and behaviors the client felt that all the self-statements would be useful. Regarding the behaviors, he thought that going swimming after work and visiting his children once per week would help him the most. Also, he thought that shopping for gifts for his wife would help him and would make her happy. The client asserted that he would have no problem in engaging in these behaviors for a specified period of time to evaluate their effectiveness in helping his depression.

Rehearsing Coping Responses

We guided the client to rehearse the chain of self-statements, until he repeated them easily. We recommended that he repeat the self-statements frequently at home, so that he would gradually foster a more positive emotional state.

Implementing and Assessing Coping Responses

To assess the effectiveness of the coping responses, the client could ask himself the following questions:

—*Have I been using my self-statements as planned?*

—*Are the self-statements helpful to relieve my depression and to forestall drinking?*

—*Do they lead me to the specified activities?*

—*Are these activities helpful?*

—*Do the self-statements come to me more automatically?*

The client found that the self-statements helped him prevent some of the drinking while he was depressed. He did not drink to intoxication. He found, however, that doing things to occupy his mind (swimming, visiting his children, and shopping for gifts for his wife) helped the most.

CASE 2: Temptations to Break the Drinking Rules

The self-monitoring records of the client indicated that she had gone over her limit, and we asked her to specify the drinking incident.

She reported that at a party she had had the four drinks allowed, according to her drinking plan, but it was still early and she did not want to leave. The client felt restless, and began to rationalize having more drinks, as follows: "I'm high already, what's the point of sticking to my rules? Breaking the rules for just one night won't make any difference. I haven't been drunk in a long time, so what the hell. I don't want to leave, and I don't think I would get through the night without breaking the rules." The client ended up drinking too much, passing out, and feeling very embarrassed the following day. A close friend told her that she made a fool of herself at the party.

In retrospect the client considered that all her rationalizations were invalid. She concluded: "It is important that I stick to my rules. According to what happened after that party, breaking the rules makes a difference. Surely I can get through the night without breaking my rules. I can rise to the challenge." On the basis of these new interpretations, the client felt that at future social events she could cope without breaking the rules, if she used the following self-statements: "It is important that I stick to my rules. I can stick to my rules." The client also felt that diluting drinks and alternating alcoholic and non-alcoholic drinks could help her get through the event. She resolved that if the temptation to break the rules was strong and she doubted her ability to cope, even if she was having fun she would leave the party.

The client was guided to rehearse the coping self-statements. We asked her to write them down, and to rehearse them before going to parties.

The client reported that as time passed it was easier for her to cope in similar situations without breaking her drinking rules. Reminding herself about her ability to stick to the rules, and diluting drinks, were the coping strategies she found most useful.

CASE 3: Relapse

The client is a 45-year-old stockbroker, who completed treatment successfully with a goal of abstinence. He is married and has three adolescent children. Prior to treatment he used to drink to cope with the pressures of his job. Every week or two he would drink heavily for about two days, usually on weekends. Three months after his discharge from treatment he

called to make an appointment with the therapist. The client said that he had a "bad" relapse, and was having doubts about himself.

In specifying the conditions of the relapse, the client reported that he drank heavily for two days to cope with the uncertainties surrounding his business, just as he did in the past. As a result of drinking he became sick, was unable to work for two days, and upset his family. All these made him feel guilty, ashamed, angry at himself, and doubtful about being able to succeed with his goal of abstinence. His appraisals of the situation were: "I'll never make it. It's not worth struggling that hard. I'm a failure."

We explored with the client the validity of his interpretations, and he concluded that they were self-defeating and inaccurate. Self-statements that he formulated to reappraise his relapse, and to convince himself that he should not abandon his goal, were: "I shouldn't be so hard on myself because of one slip. Part of life is to learn to forgive yourself for your mistakes. If I was able to abstain for three months in a row, I cannot be a total failure. This isn't time to give up on myself—I've got too much to lose. You're in the sort of business that has lots of uncertainties, you've got to accept that."

The client was guided to rehearse the chain of self-statements, and was instructed to repeat them to himself as soon as he experienced the negative feelings.

We also asked the client to formulate self-statements that he could use to *interrupt* a drinking episode before it had adverse consequences. He formulated the following: "Just because I started doesn't mean I have to go on drinking. If I keep this up I'll get into real trouble. I enjoyed the few drinks I had, why spoil it?"

At the conclusion of the session it was agreed that the client would telephone in a week to report on his progress in coping with his self-defeating thoughts.

STRATEGY FOR NEGATIVE EMOTIONS

If you feel depressed, anxious, or just generally negative because there is little or nothing you can do to change a bad situation for the better, this strategy should be useful. It may help you to relieve the negative emotions and to forestall the old coping response of drinking. This strategy may also be useful to cope with sudden urges to drink, or with temptations to break the drinking rules. Carefully follow this sequence of steps:

1. *Identify the Problem*. Negative emotions are often maintained and worsened by the way in which we think about ourselves and the world around us: when we feel depressed, anxious, lonely, guilty, etc., our thoughts tend to be negative, self-defeating, and even catastrophic. To break the circle of negative emotions, you must first recognize what these thoughts are. Ask yourself the following questions:

   - What do I say to myself when I feel the way I do?
   - To what extent are my thoughts realistic or accurate?
   - Can I support them on the basis of past experience?

   If you cannot identify your thoughts, begin to pay attention to your thinking as soon as you experience the negative emotions.

2. *Consider New Ways of Thinking or Coping Self-Statements*. To counteract negative emotions you must learn to replace negative or faulty thinking with new thinking. To do this, you can formulate self-statements that should serve the following functions:

   - To forestall the immediate tendency to drink in response to the negative feelings (e.g., "Stop and think before you make a mistake").
   - To reappraise the negative nature of the feelings and the role of alcohol (e.g., "Being depressed is not really harmful, but drinking can make it worse and make me sick").
   - To consider the consequences of drinking or not drinking (e.g., "If I drink now I'll probably feel bad tomorrow," "If I don't give in to this urge I'll feel proud of myself").
   - To remind yourself of past achievements (e.g., "In the past I have been able to cope with worse feelings without drinking").
   - To motivate yourself for alternative actions (e.g., "What else can I do instead of drinking to make myself feel better?").

   In formulating your self-statements try to make them simple and to the point, so that you can remember them easily.

3. *Select the Most Promising Self-Statements*. From the thoughts that you have just formulated, choose the ones that you think will be more

effective, not only to counteract your negative emotions but to motivate yourself to act in ways that make you feel better. Write the self-statements down to make sure that they are clearly formulated.

4. *Rehearse the Selected Self-Statements*. Practice your self-statements mentally, until you can repeat them to yourself without difficulty. While rehearsing modify the self-statements, if necessary, so as to make them more convincing.

5. *Assess the Effectiveness of the Selected Self-Statements*. Ask yourself the following questions:

   - Did I use the self-statements when I experienced the feelings that cause me the problem?
   - Were the self-statements helpful?
   - Did the self-statements lead me to do things that made me feel better?
   - Should I modify them in some way to make them more effective?
   - Are the self-statements coming to me more automatically?

STRATEGY FOR THE ATTAINMENT OF LONGER-TERM GOALS

This strategy is applied in the following situations:

1. Where clients have difficulty in developing or reestablishing activities that are required for the maintenance of the new drinking pattern (e.g., leisure activities, learning to sleep without alcohol).
2. Where clients wish to make a substantial change in an important life area (e.g., vocational, social).

When clients have difficulty in the above areas, we try to help them by means of this strategy. We stress that problems in these areas sometimes require the assistance of specialized professionals.

CASE 1: Difficulty in Developing Leisure Activities

The client is 32 years old, married, and employed in a computer company. His work involves alternate night shifts and day shifts every two weeks. When he is on night shift he drinks heavily during the day. Usually he starts drinking at home, before noon, and continues in the afternoon at a bar, where he regularly meets his buddies. At about 5:30 he leaves the bar to go to work. He requested treatment because his job was threatened. The work supervisor told him that his job performance had deteriorated, and that often alcohol could be smelled on his breath. During the Preparatory Phase the client agreed to abstain; he decided that for this period of time he would not go to the bar.

Identifying the Problem

In the second counseling session the client reported that he was having great difficulty in finding things to do during the day. Specifically, he said:

> "I don't know what to do with myself from 10:00 in the morning, when I get up, to 5:30 in the afternoon, when I go to work. By the time I get up my wife has gone to work. I am alone at home all day and feel extremely bored. I drink because there is nothing better to do."
>
> —*What have you done in the past week to relieve your boredom, besides drinking?*
> "I tried to read, but I didn't enjoy it. After working all night it is difficult for me to concentrate. Also I tried to listen to music, but it didn't relieve my boredom."
>
> —*Did you try other things, like exercising or doing chores?*
> "When I work nights, the following day I don't have much energy. I don't feel like doing physical exercise or house chores. Besides, I have never been interested in exercising or in sports."

Considering Options

We explained to the client that those who fail to fill the times previously spent in heavy drinking with other enjoyable activities have less chance of succeeding in bringing their drinking under control. We stressed that to maintain abstinence or moderation it is important to develop such activities. To identify the possible options, we ask the client the following questions:

—*Can you think of any activity that you might like to try out?*

—*Have you had any interests of hobbies that you could start again?*
After lengthy consideration the client concluded: "I cannot think of anything I would like to try out. In the past I used to play chess, and did enjoy it very much. Also, I used to like refinishing old furniture."

—*Are these options you might consider?*
"I think so, but I need to find out if there are any chess clubs in this neighborhood. The club where I used to play in my old neighborhood is far away. As for refinishing old furniture, I don't know if I can afford that hobby now."

Selecting the Most Promising Goal

To select the most promising goal, the client decided that during that week he would inquire about both activities. Through the old chess club, he would obtain information about clubs in his neighborhood. He would also examine his finances to see how much money he could put aside to buy old furniture. As he himself pointed out, since he was not drinking, he could probably afford to buy some pieces to refinish.

Formulating a Logical Plan of Action

We explained to the client that when we fail to achieve a goal, two things may be happening: the goal may be unrealistic, or our planning is poor. We asked him to specify the steps he would take to select the best goal, and to order the steps in a logical sequence.

—*Can you specify the steps you will take to find out about chess clubs? Try to arrange the steps in a logical order.*
"First, I will phone my old club to ask for addresses and telephone numbers of other clubs. I will ask particularly about chess clubs in the area of the city where I work. If they give me some addresses, I will visit those clubs that are closer to my work to find out if I can become a member."

—*Can you specify the steps you will take to find out whether refinishing old furniture is a feasible goal?*
"First, I will see how much money I could spare. Then, I will check the sale rooms to find out about prices of furniture in need of refinishing. I will also check if I still have the tools I require. When I have all this information I will discuss the plan with my wife."

—*Do you need to rehearse any of the steps in the above plans?*
The client said he was confident about being able to carry through his plans without any rehearsal.

Monitoring the Outcome of the Plan

In the following session the client reported that he was already attending a chess club which was located relatively close to his work. In the past three days he had spent the afternoons at the club, and was happy that he had had no difficulty in finding partners to play. The client had also purchased some chess books, which he was looking forward to reading.

The goal of refinishing old furniture turned out to be infeasible. After checking prices, the client concluded that he could afford to buy small pieces to refinish. However, in discussion of the plan with his wife she was not supportive. Not only does she dislike old furniture, but the smell of paint solvents makes her sick. Since the client lives in a high-rise apartment, and he cannot pursue his hobby without affecting his wife, he concluded that this goal was not practicable.

STRATEGY FOR THE ATTAINMENT OF LONGER-TERM GOALS

If you are having difficulty in planning life changes or activities that will be supportive of your new drinking pattern, this strategy should be helpful. Carefully follow this sequence of steps:

1. *Identify the Problem*. People who have difficulty in maintaining abstinence or moderate drinking often have not managed to do two things: they have not developed recreational activities that do not involve heavy drinking, and/or they have not resolved serious dissatisfactions in important life areas (e.g., employment, marriage, social). To identify the nature of your problem, ask yourself the following questions:

   - Do I frequently feel like drinking because there is nothing better to do?
   - Do I have difficulty in developing activities that do not involve heavy drinking?
   - Am I seriously dissatisfied with aspects of my life? Do I feel like using alcohol to cope?

2. *Consider Options*. Once you have identified the nature of your problem, remind yourself of the fact that we always have options. Remember to consider as wide a variety of options as you can. To identify possible options, try to answer the following questions as concretely as possible:

   - Can I reestablish old interests or hobbies that I used to enjoy?
   - Are there any activities (e.g., recreational, educational) that I might like to initiate?
   - Do I need to consult someone to find out what is available in my community regarding these activities?
   - Do I want to consider a substantial change in important areas such as my career, my marriage, my social life?
   - Do I need the help of a professional to achieve any of these changes?

3. *Select the Most Promising Goal*. Goals that are promising not only should produce desirable consequences but also should be feasible. Consider each of your possible options, and ask yourself the following questions:

   - Am I likely to maintain my new drinking pattern more successfully if I get involved in this activity?
   - Am I likely to maintain my new drinking pattern more successfully if I consider this change in my life?
   - What are the sacrifices that I will have to be prepared to make in order to achieve these changes?
   - Am I willing to make these sacrifices?
   - Will I need some type of assistance to achieve this goal (e.g., support from friends, professional guidance)?

4. *Formulate a Logical Plan of Action*. The feasibility of a longer-term goal may not become totally clear until you attempt to achieve it. In such cases, it is helpful to break the goal down into shorter-term goals, and to give some thought to the steps required to achieve each. Some thought should also be given to ways in which you can motivate yourself along the way in order to succeed. Ask yourself the following questions:

   - Do I need to break my goal into sub-goals?
   - What steps do I have to take to achieve my goal?
   - Have I ordered the steps in the right sequence?
   - Do I need to rehearse any of the steps to ensure that I can carry them through?
   - Can I do something that helps me maintain my interest in this goal?

5. *Monitor the Outcome of the Plan*. As you achieve your goal, ask yourself the following questions:

   - Do I find this change in my life helpful in maintaining my new drinking pattern?
   - Do I find the changes rewarding?
   - If not, are there modifications in my plan, or other changes, that may be beneficial?

TERMINATION OF TREATMENT

There are three ways to terminate treatment:

- Simple termination.
- Termination with referral for counseling for residual problems.
- Termination with referral to alternative treatment for problem drinking.

Simple Termination

Discharge from treatment should be considered when clients meet the following conditions:

- Sustained achievement of a desirable drinking pattern.
- Proficiency in problem solving and self-monitoring of drinking.
- Expressed confidence in the self-application of problem-solving strategies to risk situations, and to unexpected urges to drink.

A desirable drinking pattern, as mentioned earlier, is one that does not disrupt important life areas, including health.

Proficiency in problem solving may be tested, informally, by asking clients to outline the steps involved in solving a problem, and by discussing their application to risk situations. These may include interpersonal conflicts, social pressures to drink, negative emotions, or sudden urges to drink inappropriately. To assess the clients' knowledge of the strategies, you may prepare hypothetical examples of risk situations, where clients can specify how they would cope in each case to avoid drinking inappropriately.

The clients' proficiency in dealing with *sudden urges* to drink should be specifically tested. This is important because it is likely that some risk situations will not be identified during treatment, and clients should be prepared to cope with such emergencies.

The clients' confidence in their ability to apply the problem-solving strategies to risk situations may be assessed with the four-point scale described on page 13.

Just before treatment is terminated, the therapist discusses the follow-up plan, and makes these special recommendations:

- That the client continue self-monitoring drinking, so as to be able to assess progress objectively.
- That the client continue to be involved in activities that are incompatible with heavy drinking.
- That the client ask the therapist for an appointment, if he or she wishes to make major changes in his or her drinking plan, or if the client doubts his or her ability to cope in a given situation.

The client is then given a copy of *Guidelines for Safe Drinking* (Appendix C) to take away.

Termination with Referral for Counseling for Residual Problems

In our experience, once excessive drinking is brought under control, early-stage problem drinkers can usually resolve additional life difficulties on their own. On a few occasions, we have found certain problems that are beyond the scope of our program and for which clients perceive the need to be referred to a specialized professional. These problems have included:

- Serious marital or family discord.
- Poor recreational skills.
- Serious job dissatisfaction.
- Financial and legal difficulties.

Therapists are advised to check the agencies or professionals in their community who are able to deal with each of these problem areas.

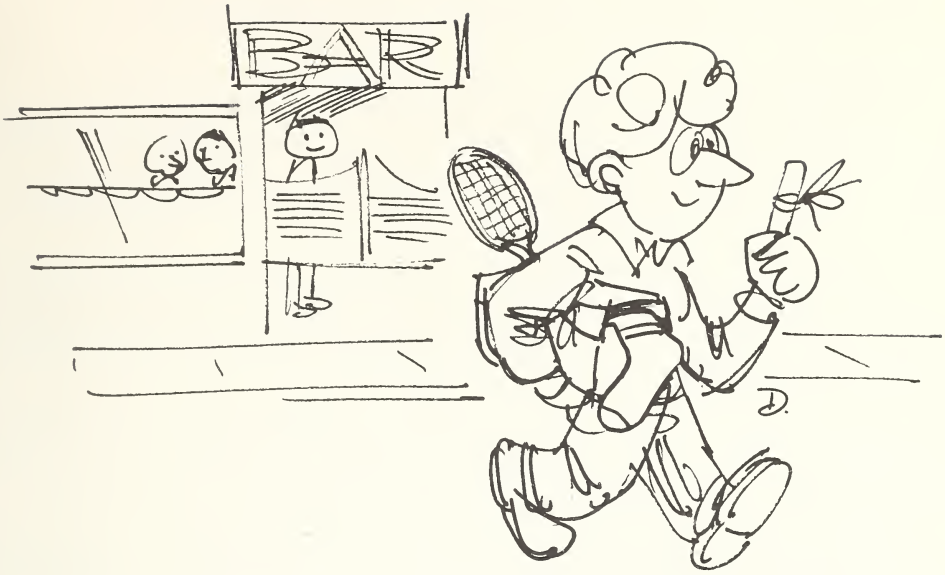
Clients are discharged from treatment in a manner similar to that described above, but therapist and client discuss the specifics of the specialized referral.

Termination with Referral to Alternative Treatment for Problem Drinking

The therapist proposes more intensive or alternative forms of treatment if:

- The client fails to make significant progress toward the drinking goal in the expected period of time, or
- The client fails to meet the expectations of the program outlined in the initial session.

If the goal was moderation, and the client is having difficulty in controlling drinking, the therapist proposes abstinence as an alternative goal, or referral to a more intensive treatment. The period of time taken to make this judgment must be established individually. We recommend, however, that no more than three months from the inception of treatment be allowed without discussing the appropriatness of the alternative treatment.



MAINTENANCE PHASE

This phase includes:

- After-Care Procedures
- Standard Follow-Up Interview

AFTER-CARE PROCEDURES

Because our preventive program was also a research study, the clients were followed up regularly to assess the outcome of the program. For the first six months after discharge from treatment, attempts were made to interview each client on a monthly basis; thereafter, follow-up interviews were conducted at 12, 18, and 24 months.

During these follow-up contacts, we had opportunity to check the clients' progress and to reinforce the continued application of the procedures taught in treatment. We insisted, particularly, on the importance of keeping drinking records.

Many of the clients reacted against the monthly follow-up interviews scheduled during the first six months after treatment. Often, however, they were more than willing to discuss their progress over the telephone.

Regular after-care contacts help to maintain the treatment gains, and are therefore recommended. They do not, however, have to be conducted face to face, and should be negotiated individually.

STANDARD FOLLOW-UP INTERVIEW

In the course of the follow-up interviews therapists should gather a minimum of standard information. This may include:

- What the quantities and frequencies of drinking have been since the last contact (i.e., when drinking was problem-free and when it caused problems).
- Maximum quantities consumed when drinking caused problems.
- Whether serious problems have occurred because of drinking, such as missing work or interpersonal conflicts.
- Whether there have been incidents of strong temptation to violate the drinking rules.
- Whether self-monitoring and problem-solving procedures are still applied and are considered to be useful.
- Whether any life stresses threaten the maintenance of appropriate levels of consumption.
- Whether an interest is maintained in other activities to replace heavy drinking.
- Whether the social milieu is supportive of the goal of treatment.

Booster sessions should be scheduled if the interview indicates a present problem or one that is developing.

BACKGROUND

This section includes:

- Theoretical Background and Research
- Controversy Surrounding Controlled Drinking
- References
- Appendices

THEORETICAL BACKGROUND AND RESEARCH

The principal conceptual influence in the development of our approach to problem drinking was the cognitive model of emotions and action described by M.B. Arnold (1960, 1969), and more specifically the elaboration of this model presented by R.S. Lazarus to explain psychological stress and the coping process (Lazarus, 1966, 1968, 1980; Lazarus et al., 1974). Briefly stated, some of the basic tenets of this model are:

- Appraisals or interpretations of objects or situations importantly influence the way we feel and behave.
- Our appraisals of a given situation can change if new evidence becomes available that alters the meaning of that situation.
- Evidence for the reappraisal of a situation—for example, from aversive to benign—can come from two sources: the situation itself (we may discover new properties that make it less noxious), or from our own coping ability (we may discover that, in fact, we can deal effectively with the stressful situation).
- Coping has two main functions: one is to act instrumentally to change a bad situation for the better (behavioral coping); the second is to regulate the distressing emotions themselves through cognitive processes (cognitive coping).
- Cognitive and behavioral coping can be effective or ineffective and, independently, can be adaptive or maladaptive. Coping is effective if it successfully attenuates aversive emotions; however, if coping responses produce adverse consequences, or prevent one from taking actions that are necessary for good functioning, they become maladaptive.

Research with Non-Alcoholic Clients

The first application of Arnold's and Lazarus's concepts to psychotherapy was carried out by the author in a doctoral dissertation (Sanchez-Craig, 1972, 1976). The aim of that study was to assess the relative effectiveness of cognitive and behavioral strategies in the reappraisal of aversive interpersonal situations. The clients were 49 pre-adolescents who wished to improve their relationships with important persons in their life (e.g., parents, teachers, peers, siblings). Two procedures were compared, alone and in combination. One was designed to elicit more positive interpretations of the stimulus person (cognitive coping), and the other to elicit reappraisal of the client's ability to cope in the difficult situations (behavioral coping). Clients were first guided to identify the most upsetting cues in the stimulus person, and their responses to those cues (i.e., their feelings, thoughts, and behaviors). In the cognitive coping condition, they were repeatedly exposed to each of these cues, both in imagination and in vivo, with the instruction that they try to find attributes in the person of which

they may have been unaware. In the behavioral coping condition, clients were helped to develop alternative behaviors in the presence of the aversive cues; the aim was to elicit more positive responses from the person who had upset them, and to increase the client's confidence in their own coping ability. As predicted by Lazarus, the development of effective coping behaviors produced a higher rate of positive reappraisals of the cues than did simply changing the client's perceptions of them. However, those who were first exposed to the cues, and thus had an opportunity to reappraise at least some of them more positively, experienced less difficulty in implementing new behaviors.

Research with Problem Drinkers

The cognitive and behavioral coping strategies described above were further developed in a halfway house for chronic alcoholics. This program was abstinence-oriented. A main interest of our research with this chronic population was to inquire about their appraisals of alcohol and alcohol-related activities when drinking was associated with problems. Residents were therefore asked to specify the antecedents and consequences of incidents of problem drinking that they remembered well. We found that in about 90% of the many incidents described, alcohol was depicted as a means of coping with stressful situations. Most of these situations were social or related to feelings and thoughts about social situations. Feelings most frequently associated with these incidents were depression, anger, loneliness, boredom, fear, anxiety, and guilt. Non-social stressful situations were mainly related to loss of jobs, anxieties about serious illnesses or chronic pain, and consequences of previous drinking.

Functions attributed to alcohol when it was used for coping were: that it would *decrease* the intensity of the negative emotions and thoughts and/or that it would *increase* the person's confidence to act in ways that would be less probable in a sober state (e.g., express anger or affection, talk to strangers, engage in sexual behavior).

The problem-solving strategies were used to teach residents how to deal more effectively with interpersonal problems and with the tendency to drink during negative emotional states. Cognitive coping strategies were taught to help them reappraise the feelings and reactions that tend to occur when drinking is stopped (i.e., the urge to drink and withdrawal symptoms). The use of cognitive coping to elicit less threatening interpretations of aversive feelings and emotions, and to make alcoholics aware that they could cope without drinking, represented a novel application of the procedures. In this setting, the problem-solving strategies were taught in small groups.

An important finding of this research was that although the clients learned the problem-solving strategies, an assessment conducted one month later indicated a poor recollection of the techniques. Moreover, very few of

the clients gave convincing examples of their application to real-life situations. The drinking outcome of the project was also rather poor, but apparently not much different from outcomes typically documented with similar client populations. In follow-up interviews conducted at 6, 12, and 18 months after discharge from the halfway house, about 10% of the sample reported abstinence for the previous six months, and about 8% reported drinking small quantities without apparent problems. A description of the halfway house program and the results of the research can be found in Sanchez-Craig and Walker (1982) and Walker et al. (1982).

The final stage of refinement of the problem-solving strategies involved their application to early-stage problem drinkers, who were treated individually as outpatients. In this project, comparisons were made of the appropriateness of the strategies in teaching either abstinence or controlled drinking. These clients were also asked to specify the antecedents and consequences of incidents of problem drinking. Analyses of these descriptions revealed that the conditions associated with problem drinking were similar in some respects to those described by the chronic alcoholics. Early-stage problem drinkers drank excessively in response to stressful events, though less frequently than the chronic alcoholics. Feelings of anxiety, boredom, depression, fatigue, and anger were most commonly experienced in these situations. Many of the incidents described involved stressful interpersonal events, but stresses arising from work or home responsibilities were also well represented. As with the chronic alcoholics, when alcohol was used as a coping device the functions attributed were: that it would decrease the intensity of the negative feelings or thoughts and/or that it would aid some kind of performance (e.g., enable the client to become more sociable, to complete tedious tasks, to speak up, or to disclose personal matters). The salient difference between the two populations was that in about one-third of the incidents described by the early-stage problem drinkers, excessive drinking was depicted as a source of pleasure or recreation (e.g., to have fun with friends, to enhance social activities, to enjoy the taste and the effects of alcohol).

In both treatment conditions the problem-solving strategies were applied to situations where drinking had been a problem in the past, to situations that tend to occur as a result of abstaining or reducing alcohol consumption or to other problems of daily life that might contribute to excessive drinking.

An initial study of this treatment indicated that controlled drinking was a much more acceptable goal than abstinence—and also that controlled-drinking clients were more able to abstain when asked to do so during the first three weeks of treatment (Sanchez-Craig, 1980). During the course of treatment (seven weeks on average), controlled drinking clients drank significantly less than abstinence clients. By the end of treatment drinking had been reduced from an average of 51 drinks per week in both

groups, to an average of 13.6 drinks in the abstinence group and 6.6 drinks in the controlled-drinking group. The significantly lower consumption observed in the controlled-drinking group may have resulted from the initial effects of random assignment to drinking goal. While most (86%) of the clients assigned to controlled drinking accepted the goal, most (66%) of the clients assigned to abstinence rejected it as a lifelong objective.

At follow-up, no significant differences in reported alcohol consumption were found between the groups. Six months after discharge from treatment the average weekly consumption in both groups was around 13 or 14 drinks. Examination of the drinking style showed that about 70% in each group reported moderate drinking (i.e., consumption not exceeding an average of 20 drinks per week); only two clients in the abstinence group and one in the controlled-drinking group reported abstinence for the six-month period. The levels of alcohol consumption and drinking styles observed at six months post-treatment were maintained by the two groups throughout the entire two-year follow-up of the study. The drinking reported by clients during treatment and at follow-up was validated using three independent sets of corroborators of alcohol consumption. These included biochemical and neuropsychological measures, and reports by collaterals (Sanchez-Craig et al., 1984).

It was concluded that for early-stage problem drinkers a goal of controlled drinking is more suitable than a goal of abstinence. First, controlled drinking was more acceptable for the majority of the clients; second, clients in the controlled-drinking condition drank less during treatment; and third, most of the clients who were assigned to abstinence developed controlled drinking on their own.

Cognitively Oriented Model of Alcohol Abuse

When we considered the notions presented by Arnold and Lazarus, and the incidents of problem drinking described by the chronic alcoholics, a "model" of alcohol abuse was formulated in which excessive drinking was viewed primarily as a means for coping with stressful events (Sanchez-Craig & Walker, 1974, 1975; Sanchez-Craig, 1975). As descriptions by early-stage problem drinkers became available, the model was further elaborated. In its present form the assumptions of the model are as follows:

- Excessive drinking frequently represents an attempt to cope with a variety of events appraised as aversive. Under such circumstances, the functions attributed to alcohol are: to reduce the aversiveness of the events themselves (whether present or anticipated) and/or to increase the person's confidence to act in ways that would be less probable in a sober state.
- Some excessive drinking also occurs, not for purposes of coping, but because alcohol or drinking is appraised as a source of pleasure or

recreation while the person is relaxed or in a pleasant mood. The person may claim, for example, that he or she enjoys the taste or the effects of alcohol, or that drinking with friends is highly enjoyable.

- The continued reliance on alcohol, either as a means for coping or as a recreational activity, can result in the development of a habitual and generalized way of responding that may have the following consequences: reduced awareness of the conditions leading up to drinking, and of the amounts consumed; increased dependence on alcohol (evidenced by the generalization of the response) which may impede the development of more appropriate coping or recreational activities; and development of social and physical consequences that in themselves provoke further drinking to cope.
- The use of alcohol may be reappraised upon discovery of new information concerning its negative effects on the life of the person. However, because of the important functions that have been attributed to alcohol, initially it is likely to be reappraised only upon discovery of rather dramatic information (e.g., being threatened with loss of job, family, or health, or causing injury through impaired driving). Such discoveries tend to counteract positive appraisals of the more immediate consequences of drinking, and to motivate people to change.
- After a decision to abstain or to reduce alcohol intake has been made, a desire to drink is likely to be experienced, especially in situations where alcohol was frequently used in the past. Relapse to inappropriate drinking is not unexpected at this stage. Such events are used to gain further understanding of the functions served by alcohol. Relapse to inappropriate drinking may be prevented by the development of cognitive and behavioral coping and recreational activities, which can lead to reappraisal of the importance of alcohol. The risk of inappropriate drinking decreases as a function of time spent drinking moderately, but occasional relapses may occur for a protracted time after the decision to abstain or to moderate drinking.

Although the above model is based on hundreds of descriptions of incidents associated with problem drinking, it is limited in a number of respects. First, the clients from whom the descriptions were obtained are not representative of the population of problem drinkers at large. Second, some of the clients gave multiple descriptions and others gave very few. Finally, the instruction given to clients to describe only incidents that they remembered well may have produced some kind of bias (i.e., are incidents well remembered because of their frequency or because of the seriousness of their consequences?). Nonetheless, these descriptions have been extremely useful. Not only have they increased our understanding of the conditions associated with problem drinking, and the functions attributed to alcohol, but they have permitted the refinement of instruments for conducting these assessments more efficiently.

CONTROVERSY SURROUNDING CONTROLLED DRINKING

Therapists interested in using this manual should be aware that for the past 20 years a controversy has raged on the issue of whether alcoholics can successfully engage in controlled drinking. This controversy has been maintained by representatives of two schools of thought: one proposing that alcoholism is a disease, and the other proposing that it is learned behavior. Advocates of the disease conception believe that alcoholism is a progressive and irreversible illness that can be arrested only if total abstinence is maintained. It is assumed that some underlying biochemical process renders the alcoholic incapable of adopting control over drinking. Alternatively, advocates of the learning conception believe that alcoholism is acquired behavior that can be modified by the use of methods based upon principles of learning. Within this framework, abstinence and moderation are both considered to be feasible goals for alcoholics. The disease view has been the most prevalent among therapists working on problems of alcohol abuse.

The main author cited by proponents of the disease concept has been Jellinek (1960), who hypothesized that alcoholism is characterized by (a) *loss of control* (i.e., the inability to stop drinking before reaching the state of intoxication); (b) *physical dependence* (i.e., the experiencing of withdrawal symptoms when drinking is discontinued); and (c) *irreversibility* (i.e., the inability of an abstinent alcoholic to resume moderate drinking, since one or several drinks will trigger loss of control). Jellinek articulated a typology reflecting the progressive nature of alcoholism, distinguishing four main types of alcoholics: *alpha*, *beta*, *gamma*, and *delta*. In his opinion, only the *gamma* and the *delta* types are true alcoholics, since they are already physically addicted (i.e., they suffer loss of control and withdrawal reactions). The only difference between these two types is their drinking pattern—while the *gamma* alcoholic drinks in binges, the *delta* type cannot refrain from daily drinking. Because the *alpha* and the *beta* types do not suffer loss of control or withdrawal reactions, they are not considered to be true alcoholics; they mainly use alcohol to alleviate emotional and physical discomfort and their addiction is supposed to be purely psychological.

Questions about the irreversibility of alcoholism were seriously raised when Davis (1962) reported that 7 of his 93 alcoholic patients had spontaneously developed moderate-drinking patterns, and that they had successfully maintained those patterns for periods of 7 to 11 years. An initial effect of Davis's report was on follow-up evaluations of alcoholism treatments. In documenting treatment success, total abstinence was no longer used as the only criterion; investigators began to discriminate those who had been drinking moderate amounts from those who had continued to drink in a pathological manner (a review of this literature can be found in Heather & Robertson, 1983). Many treatment outcome studies have consistently cor-

roborated Davis's observation that some alcoholics resume moderate drinking without apparent negative consequences, although treatment had been with an abstinence orientation. It is important to note that in at least some of these studies evidence was not presented that the alcoholics who successfully resumed moderate drinking met the criteria of *gamma* alcoholism.

A number of clinical and laboratory studies have also been conducted to examine drinking behavior in alcoholics, and to develop methods for changing patterns of abusive drinking. Laboratory studies that may serve to illustrate the fact that under certain circumstances chronic alcoholics can control their drinking are those conducted by the Baltimore group (e.g., Cohen et al., 1973). They showed, for example, that hospitalized alcoholics given an opportunity to drink substantial amounts of alcohol (up to 24 oz of 95 proof) kept their consumption at 5 oz or less in order to have access to an environment with social and recreational activities. Those who preferred to drink in isolation were relatively few. Although the ecological validity of these and other laboratory studies has been questioned, at the minimum they indicate that the notion of loss of control should be qualified.

By far the most famous clinical study was conducted by Sobell and Sobell in the early 1970s. In this study, hospitalized *gamma* alcoholics were randomly assigned to a conventional abstinence-oriented program or to a behavioral program with a goal of controlled drinking. The investigators reported a significantly superior outcome for the controlled-drinking subjects at one and two years follow-up (Sobell & Sobell, 1973, 1976). They claimed that they were able to successfully train the majority of the controlled-drinking subjects to drink in moderation. Recently, however, a group of independent investigators presented evidence indicating that the Sobells were not as successful as they had claimed (Pendery et al., 1982). Review articles on controlled-drinking issues and laboratory and clinical research can be found in Lloyd and Salzberg (1975), Briddell and Nathan (1976), Miller and Caddy (1977), Miller and Hester (1980), Heather and Robertson (1983), and Marlatt (1983).

Despite the numerous research efforts, the representatives of neither the disease nor the learning concepts have been able to provide incontrovertible evidence to support their positions. Perhaps they never will, since it is not clear that the two positions are mutually exclusive. There may be a general tendency to drink alcohol that in part may be biologically determined. However, this tendency may only be revealed in conditions under which drinking behavior can be acquired. Although controlled drinking has been successfully achieved by some alcoholics, the bulk of empirical evidence clearly indicates that those who succeed are typically younger, more socially stable, and less chronic—that is, they tend to have shorter drinking histories and fewer alcohol-related disabilities (see Miller & Caddy, 1977; Polich et al., 1981; Heather & Robertson, 1983). Clinicians who more recently have conducted controlled-drinking studies have selected their

clients on the basis of criteria reflecting social stability and an alcohol problem in the early stages of development (e.g., Alden, 1978; Pomerleau et al., 1978; Miller et al., 1980; Miller et al., 1981; Sanchez-Craig et al., 1984). The present tendency among clinicians with a behavioral orientation is to restrict controlled drinking programs to early-stage problem drinkers, since they are the ones for whom this goal seems to be most appropriate.

In summary, there is evidence that moderate drinking is an appropriate goal in the treatment of socially stable early-stage problem drinkers. This manual has therefore been developed to assist therapists in treating this group, who, although less conspicuous than the deteriorated alcoholic, represent the majority of persons with alcohol problems.

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Appendix A

ANALYSIS OF FUNCTION QUESTIONNAIRE
(M. Sanchez-Craig and D.A. Wilkinson)

Drinkers attribute many functions to alcohol. We have identified six types of functions that heavy drinkers often attribute to alcohol. The purpose of this exercise is to recognize the functions that clients have attributed to alcohol when their drinking has been moderate and when it has been excessive.

For each one of the functions described below, please indicate whether in the past 3 months: drinking *never* occurred, or if it did occur, whether is was *problem-free*, *associated with problems*, or *both*. Subsequently, rank those situations in which drinking was associated with problems, according to their relative frequency (assign No. 1 to the most frequent, No. 2 to the one that follows, and so on).

	Drinking Never Occurred	Drinking Was Problem-Free	Drinking Was Associated with Problems	Rank
1. To relieve negative feelings or emotions (e.g., anxiety, depression, loneliness, fear, guilt, boredom, sadness, frustration, lack of confidence).	( )	( )	(✓)	(1)
2. To help in doing something that would be less probable without drinking (e.g., express anger or affection, engage in sexual behaviour, express opinions, complete tedious tasks, talk to strangers, dance).	( )	(✓)	(✓)	(3)
3. To medicate oneself (e.g., to relieve physical pain, hangover, help sleep).	(✓)	( )	( )	( )

4. To reduce social pressures, or to be part of the crowd (e.g., when alcohol is freely available, when it is difficult to refuse invitations to drink).	(✓)	( )	( )	( )
5. To have pleasure (e.g., to enjoy the taste of a beverage or the effects of alcohol, to have fun with friends, to enhance meals, to quench thirst).	( )	(✓)	(✓)	(2)
6. Drinking is habitual, for no particularly identified purpose (e.g., at the same time, in the same place, with the same people).	( )	(✓)	( )	( )
7. Other: _____	( )	( )	( )	( )

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Date _____

Appendix A (Cont.)

SPECIFIC INCIDENTS OF PROBLEM DRINKING*

Think first of the incident that you wish to describe, and then answer the following questions as concretely as possible:

1. *ANTECEDENTS*

Where were you and with whom when the *decision* to drink was made? at work

What were you feeling before you drank? angry, frustrated

Were you preoccupied by anything? wondering if I could put up with the unfair criticism of my supervisor

3. *CONSEQUENCES*

Describe what happened after you consumed the first two or three drinks (e.g., became less anxious or angry, became more talkative or assertive, made more threats or sexual advances, felt happier).

became less angry

What *function(s)*, if any, did you expect alcohol or drinking to serve in this situation?

help me forget

2. *CONTEXT OF DRINKING*

Where were you and with whom when the *actual* drinking occurred?

at home, with my wife

Describe what happened with continued drinking (e.g., felt sick, guilty, depressed, passed out, got into a fight, spent too much money, missed work, was charged with impaired driving).

got into a fight with my wife about the way in which I handle pressures at work

4. *FINAL APPRAISAL*

Did alcohol, or drinking, actually serve the expected functions in the particular incident? If not, specify: Initially, yes, but next day I was still angry. Also felt guilty about upsetting my wife.

*Incidents similar to the present one occurred once or twice per week, with different consequences. Not always did he fight with his wife. Usually he had a hangover.

Date _____

Appendix A (Cont.)

SPECIFIC INCIDENTS OF PROBLEM DRINKING*

Think first of the incident that you wish to describe, and then answer the following questions as concretely as possible:

1. *ANTECEDENTS*

Where were you and with whom when the *decision* to drink was made? at the gym, with friends after playing basketball

What were you feeling before you drank? O.K., physically tired

Were you preoccupied by anything? nothing in particular

3. *CONSEQUENCES*

Describe what happened after you consumed the first two or three drinks (e.g., became less anxious or angry, became more talkative or assertive, made more threats or sexual advances, felt happier).

had fun and told jokes

What *function(s)*, if any, did you expect alcohol or drinking to serve in this situation? relax with friends

2. *CONTEXT OF DRINKING*

Where were you and with whom when the *actual* drinking occurred? pub

Describe what happened with continued drinking (e.g., felt sick, guilty, depressed, passed out, got into a fight, spent too much money, missed work, was charged with impaired driving). got home late, my wife was angry, next day I was hangover at work.

4. *FINAL APPRAISAL*

Did alcohol, or drinking, actually serve the expected functions in the particular incident? If not, specify: yes, but the final consequences were bad

*The client reported that incidents similar to the present one occurred once per week during the past 3 months.

Date _____

Appendix A (Cont.)

SPECIFIC INCIDENTS OF PROBLEM DRINKING*

Think first of the incident that you wish to describe, and then answer the following questions as concretely as possible:

1. *ANTECEDENTS*

Where were you and with whom when the *decision* to drink was made? At my inlaws, when visiting for Sunday dinner

What were you feeling before you drank? Bored and restless

Were you preoccupied by anything? thinking about the time to go home

3. *CONSEQUENCES*

Describe what happened after you consumed the first two or three drinks (e.g., became less anxious or angry, became more talkative or assertive, made more threats or sexual advances, felt happier).

socialized better

What *function(s)*, if any, did you expect alcohol or drinking to serve in this situation?

help me get through the night

2. *CONTEXT OF DRINKING*

Where were you and with whom when the *actual* drinking occurred?

at my inlaws, before, during, and after supper

Describe what happened with continued drinking (e.g., felt sick, guilty, depressed, passed out, got into a fight, spent too much money, missed work, was charged with impaired driving).

fell asleep on the couch

4. *FINAL APPRAISAL*

Did alcohol, or drinking, actually serve the expected functions in the particular incident? If not, specify:

yes.

*Incidents similar to this occurred about twice a month.

IDENTIFICATION OF RISK SITUATIONS AND REQUIRED COPING SKILLS

1. Specify the principal risk situations, and the functions attributed to alcohol in these situations:

The risk situations for this client are as follows:

(a) He drinks to cope with anger or frustration, provoked by what he perceives to be unfair criticisms from his work supervisor

(b) He drinks to have fun

2. Specify how the client will cope in these situations. Identify particular cognitive and behavioral coping skills:

The coping skills that this client needs to develop are:

(a) Learning to express anger constructively to his supervisor.

(b) Learning how to refuse drinks from his friends.

with his friends, after playing basketball.
(c) He drinks to cope with boredom, when he goes for supper at his inlaws.

(c) Learning how to pace drinking at the pub and at his inlaws.

Appendix B

SUCCESSFUL COPING WITH URGES TO DRINK AND SOCIAL PRESSURES

URGES/TEMPTATIONS	SOCIAL PRESSURES
Where and with whom: watching football on T.V. alone	Where: after work
Feelings: good	Who invited: co-workers
Self-statements: "I can enjoy this game without a beer."	What did you say: "My wife and I are going out tonight."
Behaviors: poured my self a coke	What did you do: took my wife out to dinner
Where and with whom: at home, alone	Where: at a party
Feelings: sad	Who invited: friends
Self-statements: "I shouldn't drink, my wife will be home in a few hours."	What did you say: "I've reached my limit for tonight" "I don't feel like a drink"
Behaviors: watched a movie on T.V.	What did you do: had soft drinks and left early

Where and with whom: at home, after an argument with my wife

Feelings: angry

Self-statements: "Drinking will only make it worse."

Behaviors: went to the basement to do chores, then talked to my wife

Where: at a friend's house

Who invited: my friend

What did you say: "I have to drive"

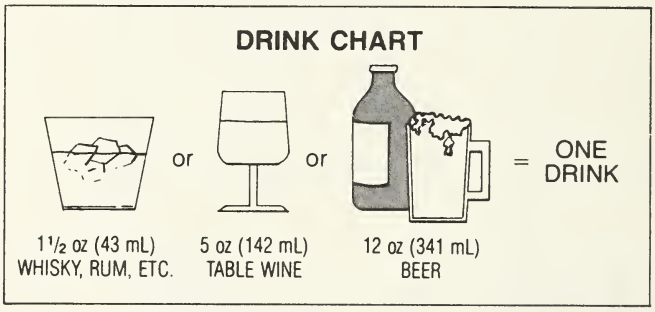
What did you do: drank coffee

Appendix C

GUIDELINES FOR SAFE DRINKING

Problem drinkers who have been successful in reducing their drinking to safe levels tend to adopt the following rules:

- DO NOT DRINK DAILY
- DRINK NO MORE THAN 4 DRINKS PER DAY
- DRINK NO MORE THAN 20 DRINKS PER WEEK



A safe drinking pattern is one that does not interfere with your health or important responsibilities at work or home. Also, this pattern should fit well into your lifestyle.

Five Steps for Appropriate Drinking

1. *Pace Drinking*. Slow drinking down so that intoxication is avoided by:
   - carefully measuring drinks
   - diluting drinks, rather than drinking them straight
   - sipping drinks, rather than gulping them
   - alternating alcoholic and non-alcoholic drinks
   - avoiding drinking on an empty stomach.

2. *Keep Records*. To see how you are progressing, it is important to maintain a *daily* record of how much you drink. Just as you would need an accurate scale if you were trying to lose weight, you need an accurate record of drinking when you are trying to cut down. Those who

succeed on cutting down on their drinking usually keep recording their alcohol use until the safe pattern is well established. Also keep notes of ways you find of successfully dealing with temptations to drink too much, and with pressures from others to drink.

3. *Prepare Yourself to Avoid Heavy Drinking.* Drinking rules are most often broken in situations where alcohol is readily available, or where pressures from others are strong. To avoid heavy drinking in such situations you should develop strategies:

   - to counteract temptations to go over the limits (e.g., "Oh, well, I'm not working tomorrow." "I'll only have one more.")
   - to refuse drinks without feeling guilty or antisocial (e.g., "I've reached my limit." "I don't feel like having another drink.")
   - to leave the situation if your coping ability is doubtful (e.g., by having an excuse at hand).

4. *Get into Activities That Don't Go with Heavy Drinking*. A safe drinking pattern can be better achieved if you develop new interests that don't allow for heavy drinking to occur at the same time (e.g., physical fitness or educational activities). These activities allow you to fill the times that used to be spent in heavy drinking. It is also best to avoid people who are likely to encourage you to drink (if you've chosen abstinence) or overdrink.

   If you are often tempted to drink out of boredom, it is especially important to develop new interests or recreational habits. This is not always easy; it requires some discipline and, perhaps, the assistance of a professional.

5. *Cope with Problems of Daily Living*. Reasons that problem drinkers frequently give for heavy drinking are:

   - to cope with unpleasant emotions (when they feel depressed, bored, anxious, lonely, guilty, etc.)
   - to help themselves in doing things that otherwise they wouldn't do (in expressing anger or affection, in becoming more sociable or assertive, in being able to complete tedious tasks, etc.)
   - to enjoy themselves (e.g., because they like the taste of alcoholic drinks or the effects of intoxication, because they would not enjoy parties or social gatherings without drinking)
   - to medicate themselves (e.g., to help sleep, to reduce physical pain).

Everyday problems can upset your plans to change your drinking. Therefore, it is important to find adequate solutions to those problems as quickly as possible. This may require professional help. The rule to keep in mind is that alcohol *should not* be used to cope with problems.

ABOUT THE AUTHOR

Martha Sanchez-Craig is a clinical psychologist with the Addiction Research Foundation. She completed undergraduate work in philosophy and psychology in her native Mexico and subsequently earned her PhD in counseling psychology at the University of Toronto. Since 1973, Dr. Sanchez-Craig has pioneered cognitive-behavioral interventions applied to problems associated with excessive drinking.